An Exploration of Dance/Movement Therapy for

Asian American Clients with Depressive Symptoms

A Thesis

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DEDICATIONS

I lovingly dedicate this thesis to the memory of my grandfather; a man whose courageous sacrifices enabled our family to pursue education and experience the "American Dream". His love for his heritage planted the seed that would grow into my affinity for working with immigrants and multiculturalism.

This work is also dedicated to the participant of this study, who demonstrated openness, bravery, and enthusiasm in sharing herself with me during this process. Her commitment made this study possible.

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ABSTRACT

An Exploration of Dance/Movement Therapy for
Asian American Clients with Depressive Symptoms
Julia L. Cuccaro
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The research objective of this thesis was to describe the dance/movement therapy (DMT) process as it developed with a Chinese American client with depressive symptoms. One participant was recruited to participate in this qualitative case study, which was comprised of an initial interview process, three DMT sessions with subsequent journaling and discussion time, and a final interview to obtain the participant's reflections on her experience with the DMT. Five sources of data were collected, including the researcher's notes from the initial interview; researcher field notes, participant journal entries, and a transcription of the discussions between researcher and participant from each of the three DMT sessions; and then a transcription from the final interview. The study found 6 themes, including: (a) the development of the therapeutic relationship, (b) the importance of dedicating time to understanding, (c) DMT as a support in expressing and accepting feelings, (d) valuing and experiencing relaxation and release, (e) the preference for a structured and solution-based therapeutic approach, and (f) Chinese culture and views on mental health. The findings suggest that dance/movement therapy may be a culturally congruent form of therapy for Chinese Americans with depressive symptoms and that it may provide an alternative method for expressing and releasing feelings that are discouraged from being verbalized.

CHAPTER 1: INTRODUCTION

The purpose of this qualitative case study is to describe the form of and client response to dance/movement therapy with Asian American clients with depressive symptoms in terms of its potential as a culturally congruent course of therapy. This study involved a brief course of dance/movement therapy with a Chinese American woman, in which an initial interview, three dance/movement therapy sessions with subsequent journaling and discussion time, and a final interview were conducted. Prior to the study and again before the data analysis, the researcher engaged in a reflexive procedure through journaling and movement. The rationale for this study is to address the issue of culturally competent therapy for Asian Americans with depressive symptoms, taking into consideration cultural factors such as the varying expression of depressive symptoms, stigma about mental illness and therapy, and client-perceived congruency of therapy.

Research indicates that Asian Americans both experience and present with depressive symptoms differently than Caucasians, particularly with the presence of somatic symptoms (Waza, Graham, Zyzanski, & Inoue, 1997; Yen, Robins, & Lin, 2000). Yen, Robins, & Lin (2000), in their study of Chinese patients, discuss that patients with the diagnosis of neurasthenia, which includes symptoms of fatigue, weakness, sleep disturbance, poor concentration, poor memory, and bodily pain associated with muscle tensions, are often able to be rediagnosed with major depression when using the criteria of the DSM. Waza, Graham, Zyzanski, & Inoue (1997) found that Japanese patients often reported with abdominal distress, headaches, and neck pain in addition to some of the criteria outlined in the DSM. These distinctions can have an influence on diagnosis, which has been found to

have a Western bias that does not always take cultural differences into consideration (Kim & Chung, 1993; Lehti, Johansson, Bengs, Danielsson, & Hammarström, 2010).

As of 2007, there were over ten million Asian Americans living in the United States, so it is critical that mental health practitioners are able to treat them with a cultural awareness (Sue and Sue, 2008). To do that, it is necessary for counselors and therapists to have an understanding of the distinctive characteristics of the multiple ethnicities and cultures encompassed by the label, Asian American, and how they influence mental illness and treatment for that population. For instance, a review of the literature shows that Asian Americans report a stigma surrounding depression and are less likely to seek treatment from professionals because they attribute the symptoms to internal causes (Fogel & Ford, 2005; Wong, Kim, & Tran, 2010). Ethnic minorities, including Asian Americans, are also less likely to believe that depression has a biological basis, and therefore more likely to believe that counseling is a more effective treatment than antidepressants (Givens, Houston, Van Voorhees, Ford, & Cooper, 2007). Furthermore, Asian Americans diagnosed with depression or anxiety may be less likely to use antidepressants than their Caucasian counterparts, even when factoring out mental health need and socioeconomic factors (Gonzalez, Tarraf, West, Chan, Miransa, & Leong, 2010). Taking this research into consideration, it is important to explore other venues of treatment that may be more consistent with Asian American values and beliefs.

Research has shown that dance is an effective intervention for decreasing depression and increasing vitality in psychiatric patients with depression (Koch, Morlinghaus, & Fuchs, 2007). However, these results have yet to be replicated, nor have they been researched with the special considerations of an Asian American population or using dance/movement

therapy specifically as the intervention. Dance/movement therapy itself is a modality whose form responsively shifts to meet the needs of clients. Chaiklin and Schmais (1979) describe the technique of Marian Chace, one of the founders of dance/movement therapy, of assessing elements of group dynamics, mood, and general atmosphere of a group of clients to determine how the dance/movement therapy session should begin to meet the clients empathetically at their level. This is a practice that many dance/movement therapists engage in, which demonstrates the improvisational nature of dance/movement therapy. This study will begin to investigate the form that dance/movement therapy takes with Asian American clients and how they respond to the therapy, which will begin to determine whether or not dance/movement therapy may provide a culturally congruent course of therapy in which Asian American clients with depressive symptoms are able and willing to invest. With this information, it can be decided if research on the effectiveness of dance/movement therapy for this population is an appropriate direction to pursue.

It is critical that practitioners become aware of the development and frame of reference for their specific discipline's approach to the therapeutic process and how that may have been influenced by cultural norms. Chang (2006) discusses the importance of this task:

> Now considered traditional, such [historical] educational approaches and psychological theories continue to dominate many areas of clinical practice (Dokter, 1998)… However, psychological concepts conceived under predominantly Western and middle class values remain the dominant diagnostic and treatment paradigm (Gilroy, 1998; Littlewood, 1992b)… If applied uncritically, classically oriented DMT epistemologies can inherently reproduce racial bias and impede treatment with patients or clients from non-dominant cultures, or ethnic groups differing from the therapist's (Hanna, 2004). Instead of perpetuating what psychiatrist S. Acharyya terms 'neo-colonial' attitudes and practices in psychiatry (Acharyya, 1992, p. 80), creative arts therapists must become *culturally competent* (Sue, 1981) in creating

> interventions to foster the bodymind (Pert, 2002; Saltonstall, 1988) health of clients from non-majority cultures (p. 192-193).

In order to adequately serve clients, therapists must consciously work towards the cultural competency that Chang (2006) calls the field to develop and to examine the Western framework that has influenced the development of dance/movement therapy.

Dance/movement therapy may be a fitting course of treatment as it incorporates the body in the therapeutic process, and this orientation may mediate treatment challenges related to stigmatized mental health issues. For instance, Chang (2006) found in her research of Korean students that "verbal self-disclosure—or *sharing*, as it is known in both countries from humanistic psychology—was not perceived as culturally congruent by most members," (p. 201). Furthermore, "traditional Korean dance valorizes *Salp'uri*, a solo dance whose most respected performers are mature women. Dancers are held in high regard, and the best dancers personify and express emotions that are typically suppressed, such as bitterness and suffering (Loken-Kim, 1989)," (Chang, 2006, p. 202). These findings from Chang's (2006) research indicate a possible opening for dance/movement therapy, which allows clients leeway with whether or not they engage in verbal disclosure while providing an expressive outlet through movement.

The problem of cultural diversity in the manifestation of depression has begun to be addressed from several angles. For instance, there has been a recent increase in the creation of culturally sensitive depression scales (Lam, Pepper, & Ryabchenko, 2004; Koh, Chang, Fung, & Kee, 2007). The unique considerations for Asian Americans with depression have been acknowledged through this advancement. However, this information has not yet been translated into practice and examined from the perspective of implications for treatment. An in-depth examination of this would benefit mental health practitioners and the Asian

American clients they serve. Asian Americans may benefit as the study contributes to the development of culturally congruent forms of therapy, which may make treatment more comfortable and effective. Clinicians may benefit by increasing their knowledge and awareness of this population, and thereby improving their effectiveness in working with clients of this cultural background.

The majority of the research previously executed has surrounded issues of creating culturally sensitive scales. While much of this research has been successful in providing the community with more accurate information about depression in Asians and Asian Americans, it has not generated treatment solutions. Consequently, there is a need for research to investigate how Asian Americans respond to various methods of psychological treatment.

Dance/movement therapy research in specific relation to the Asian American population is limited. Pallaro (1997) theorizes about a dance/movement therapy approach for working with Asian Americans, but no research has been published about the effectiveness of this method. Dance/movement therapy may be a promising approach to pursue in therapy with Asian Americans because it works through the body, and Asian Americans tend to report somatic symptoms related to depression more often perhaps because of an implied need to avoid stigmatizing the family (Yen, Robins, & Lin, 2000). Chang (2006) has also published work about the use of dance/movement therapy with Asian Americans, but her studies have focused on the training and education of dance/movement therapists and Asian Americans in these programs. The research done on the effectiveness of dance/movement therapy as a treatment for depression has limitations, most notably sample size and lack of control groups, leaving room for more work to be done with respect to efficacy.

This study seeks to answer the research question, how do Asian Americans with depressive symptoms respond to a brief course of dance/movement therapy, and what form does dance/movement therapy take with this population. The research objective is to describe the dance/movement therapy process as it unfolded with an Asian American client with depressive symptoms to explore the fit of DMT and adaptations that may support culturally competent therapy with this population. It is also important to note that the therapist/researcher is a Caucasian female who was raised, educated, and trained in dance/movement therapy in the United States, so the study inherently has a cross-cultural dynamic.

Six themes emerged from the data gathered during a brief course of DMT with a Chinese American woman. The six themes include: (a) the development of the therapeutic relationship, (b) the importance of dedicating time to understanding, (c) the support of dance/movement therapy in the expression and acceptance of feelings, (d) valuing and experiencing relaxation and release, (e) the preference for a structured and solution-based therapeutic approach, and (f) Chinese culture and views on mental health. These findings provide a qualitative richness through narrative that gives some insight into the experience of both the participant and the researcher in this cross-cultural DMT relationship.

There are several study limitations. The recruitment procedure involved participants from the same health center. Only one participant responded to recruitment and enrolled in the study. As such, the study doesn't have enough participants to differentiate between nationalities. As a qualitative case study with only one participant, the results are not generalizable to a larger population; however this study raises questions that may provide grounds for further research. Limitations might be encountered in the self-report data in the

interviews and journals, because they are subject to the participant's abilities to self reflect and accurately describe her experiences. Cultural misunderstanding or misinterpretation is possible on both the side of the Caucasian co-investigator as well as the Asian American participant. Finally, the brief time frame of this therapy intervention may not give a comprehensive understanding of how dance/movement therapy might be used for Asian Americans with depressive symptoms.

CHAPTER 2: LITERATURE REVIEW

This review of the literature will provide a brief context of culture, ethnicity, and acculturation, as well as the development of multicultural competencies and approaches to cross-cultural relationships in counseling. It will then explore Asian American cultural values and the possible variations in perspectives they may have on mental health, the role of culture in symptomatology and diagnosis, and cultural considerations in treatment and help-seeking. A history of dance/movement therapy will be provided, in addition to a review of its effects on depression. Finally, the literature that intersects between culture and the creative arts therapies will be considered.

Definitions of Culture, Ethnicity, and Acculturation

Judith Lynn Hanna (1990), an anthropologist specializing in the relationship between dance and society, defines culture as "a dynamic, *ever-changing* phenomenon encompassing the values, beliefs, attitudes, and learned behavior shared by a group," (p. 116). She explains that cultural groups can be distinguished by a number of characteristics, including ethnicity, race, age, sex, occupational group, or even by a particular sick role. Culture can be represented in a group's style of movement, modes of communication, and in the way that they view and understand health and illness within the context of the other aspects of their lives (Hanna, 1990).

According to Dosamantes-Beaudry (1997b), a dance/movement therapist and psychologist, the mother-infant relationship is the carrier of a culture's core beliefs, values, myths, expressive style, and ways of structuring relationships. She also compares

traditionalist and modernist cultures and asserts that the different elements of the mother-child relationship that are emphasized in each type of culture influences the conception of self that is developed in an individual (Dosamantes-Beaudry, 1997b).

McGoldrick, Giordano, and Garcia-Preto (2005) edited the foundational text on ethnicity in the context of family therapy and explore each ethnicity's cultural values and history, particularly as they relate to mental health and clinical applications and with specific attention to individual nationalities within each ethnicity. They describe the complexity of ethnicity and its influence:

> Ethnicity, the concept of a group's "peoplehood," refers to a a group's commonality of ancestry and history, through which people have evolved shared values and customs over the centuries. Based on a combination of race, religion, and cultural history, ethnicity is retained, whether or not members realize their commonalities with one another. Its values are transmitted over generations by family and reinforced by the surrounding community. It is a powerful influence in determining identity. It patterns our thinking, feeling, and behavior in both obvious and subtle ways, although generally we are not aware of it. It plays a major role in determining how we eat, work, celebrate, make love, and die (p. 2).

The authors assert that although ethnicity has previously been used by the dominant group to describe "otherness" and to enumerate how "minority" groups differ from their perception of "normality," it is a concept that is relevant to everyone, not just those the dominant group label as different from them (McGoldrick, Giordano, & Garcia-Preto, 2005).

Acculturation is a measure of the extent to which a person aligns themselves with the attitudes, life-styles, and values of the dominant culture, and is often influences by the individual's age, amount of time residing in the dominant culture, levels of education, exposure to racism, and socioeconomic status (Lee & Richardson, 1991). Sue and Sue

(2008), authors of one of the most authoritative texts on diversity and multiculturalism in counseling, add that stress caused by acculturation can create a conflict of biculturalism. Immigration experiences, language differences, and adjusting to the way of life alongside the dominant culture in America can all contribute to this stress (Sue & Sue, 2008).

Multicultural Competency in Therapy

Sue, Arredondo, and McDavis (1992) wrote a seminal article introducing multicultural perspectives and competencies as a call to the profession of counseling. They developed a framework of multicultural competency that involved three characteristics by three dimensions. It was widely published with the hope that it would become standard for the training of helping professionals. These characteristics included counselor awareness of own assumptions, values, and biases; understanding the worldview of the culturally different client; and developing appropriate intervention strategies and techniques. For each of these characteristics, three dimensions apply: beliefs and attitudes, knowledge, and skills. The Professional Standards committee of the Association for Multicultural Counseling and Development urged the field to apply this framework to integrate multiculturalism into the education, training, research, and practice of all counselors (Sue et al, 1992). Arredondo, Toporek, Pack Brown, Jones, Locke, Sanchez and Stadler (1996) followed up this article with an operationalization of multicultural counseling competencies by further elaborating on the elements within each dimension of each characteristic that are necessary for multicultural competency (Arredondo et al, 1996).

Sue and Sue (2008) identify six themes relevant to a definition of multicultural counseling. The first is the broadening of the helping role and the process of therapy. Next

is to make the modalities and goals of the therapy consistent with the life experiences and cultural values of the client. Thirdly, the therapist must address the individual, group, and universal dimensions of a client's identity. Balancing the knowledge we have of universal versus culture-specific elements is also critical to successful multicultural counseling, as is incorporating aspects of individualism in addition to collectivism. Finally, it is important to consider both the client and the system in which the client must reside. Sue and Sue (2008) also propose that a therapist who has multicultural competency has developed three specific skills. These competency skills include awareness of the therapist's own assumptions, values, and biases; understanding the worldviews of culturally diverse clients; and developing appropriate intervention strategies and techniques based on this knowledge. Furthermore, therapists must find balance on the cultural universality versus cultural relativism spectrum and account for the sociopolitical implications in oppression and power dynamics (Sue & Sue, 2008).

With consideration for these facets of multicultural counseling, Sue and Sue (2008) propose a tripartite framework of identity. This model aims to incorporate the unique characteristics and experiences of each individual, the similarities that are shared on a group level, and the universal parallels that all humans have in common as members of our species in creating a holistic understanding of a client. The authors assert that Western psychology tends to have a bias that focuses on the individual and universal levels of identity as opposed to the group level of identity, which is where racial, ethnic, and other group affiliations reside (Sue & Sue, 2008).

Hanna (1990) emphasizes that an anthropological perspective in understanding a culture's belief systems and patterns of behavior is critical to providing effective care as

dance/movement therapists. She maintains that "how therapeutic activities are culturally conceived; what the criteria are for who participates, when, where, how and with whom; what is preferred, prescribed, and prohibited; and what movements, postures, gestures, use of space and transitions, phrasing, dynamics, etc. mean" are all critical components for a therapist to be aware of in ensuring multicultural competency and fair distribution of services (p. 124).

Multicultural competency also includes working with an awareness of barriers to multicultural counseling. Sue and Sue (2008) suggest that many of the Western culture-bound values that influence therapy can be barriers to providing effective therapy to culturally diverse clients. They cite focusing on the individual, expectations of verbal, emotional, and behavioral expressiveness, insight-driven techniques, avoidance of self-disclosure, emphasis on scientific empiricism, the division of mental and physical health, and the ambiguity of the psychotherapeutic process as values that are foundational to the Western approach to therapy. Class-bound values, differences in patterns of communication, and language barriers are also potential barriers to multicultural therapy (Sue & Sue, 2008).

Cross-Cultural Relationships in Therapy

Dosamantes-Beaudry (1997b) asserts that understanding a culture outside of one's own is difficult because the majority of cultural rules are enacted nonverbally and unconsciously. These seemingly innate elements of culture dictate the expressive style of a culture. Subsequently, an individual's body image and body boundaries are the most visible statement of their cultural identity. The author discusses two categories of cultures, although it is also possible for individuals to have a hybrid of these two types. A traditionalist culture

tends to explain mysteries using spirituality, emphasizes family and community, and separate roles by gender and age. Modernist cultures tend to use science to explain mysteries, emphasize individuality, and minimize gender- and age-specific roles. Japanese culture is used as an example, where proper body control and behavior of an individual is tied to their family's reputation and can cause collective damage (Dosamantes-Beaudry, 1997b). When working with clients of a different cultural background from oneself, the author advises that therapists should take care to address instances of expressive or stylistic differences that are unfamiliar and may indicate the client's cultural subconscious to insure that the therapist does not unconsciously impose his or her own cultural worldview. This is important because different cultures can use different defense mechanisms and can have different interpretations of their symbolic experiences. Dosamantes-Beaudry (1997b) proposes the need for multicultural flexibility, or the ability to shift from one cultural orientation to another and work with a synthesized cultural viewpoint, when treating culturally diverse clients. The author asserts that particular attention should be given to the nature of self and other relationships in the client's cultural worldview, and offers respectfulness, empathy, humor, and empowerment as tools that are critical to the development of a therapeutic relationship that has multicultural sensitivity (Dosamantes-Beaudry, 1997b).

Sue and Sue (2008) detail several techniques in navigating cross-cultural therapeutic relationships. First, the authors discuss how differences between therapist and client are often visually noticeable, or can otherwise be revealed, as in the case of religion, sexual orientation, or presence of an accent. In this instance, they suggest acknowledging these differences and investigating client reactions to them. This is critical because it can affect the therapeutic relationship and the ability to build trust between client and therapist. The

authors also suggest that self-disclosure can be a helpful approach in reducing concerns about differences and could even introduce feelings of similarity between the pair (Sue & Sue, 2008). McGoldrick, Giordano, and Garcia-Preto (2005) offer that an individual outside of a particular culture will never fully understand that culture, but suggests that an approach with humility, curiosity, and awareness of one's own cultural background will go a long way towards being culturally sensitive.

While Sue and Sue (2008) state that it is a common belief that matching therapists and clients on various cultural dimensions because of assumed similarity of experience, they also emphasize that there is insufficient research to support this claim. However, the authors state that certain combinations may be more or less problematic, using the example that the research seems to suggest that matching ethnicity for Asian American clients is important. They suggest that this could be influenced by language barriers, the degree to which clients adhere to their culture's traditional values, differences in verbal and nonverbal communication styles, and the therapist and clients stage of ethnic identity. As such, they recommend further study on all aspects of cross-cultural therapy and therapeutic relationships (Sue & Sue, 2008).

Asian American Culture and Mental Health

Asian American Cultural Values and Beliefs

Asian Americans are often named the "model minority" because of statistics that indicate their academic and professional success, but these statistics can be deceiving in that they don't represent Asian Americans as a whole, and can be more representative of certain Asian American populations over others (Sue & Sue, 2008; Lee, Blando, Mizelle, & Orozco,

2007). Therefore, Sue and Sue (2008) describe the importance of understanding the impact of the myth of the "model minority" on mental health:

> Although Asian Americans underutilize mental health services, it is not clear if this is due to low rates of socioemotional adjustment difficulties, discriminatory mental health practices, or cultural values inhibiting self-referral (Asai & Kameoka, 2005). It is possible that much of the mental illness, adjustment problems, and the juvenile delinquency among Asians are hidden. The discrepancy between official and real rates of adjustment difficulties may be due to cultural factors such as the shame and disgrace associated with admitting to emotional problems, the handling of problems within the family rather than relying on outside resources, and the manner of symptom formation, such as a low prevalence of acting-out disorders (p. 361).

For these and many other reasons, it is critical that clinicians look beyond this stereotype of the "model minority" and seek to understand each individual's circumstances and experiences. While generalizations can be helpful, the authors note the importance of realizing that values and beliefs fall along a spectrum of traditional to acculturated, that within-group differences are just as significant as between-group differences, and that a culture's or individual's beliefs are malleable over time (Sue & Sue, 2008).

Asian Americans tend towards a collectivist orientation and consequently tend to value the needs of their family or affiliated group over their individual identity and self-advancement. The family as a unit tends to be hierarchical, placing male and older individuals in positions of authority. As such, traits of obedience and filial piety are valued and parenting styles often favor an authoritarian and directive approach (Sue & Sue, 2008; Lee & Mock, 2005). Emotionality is discouraged in many Asian American cultures and is often viewed as lacking restraint and immature. Parents may use shame or guilt to help reinforce this in children. Instead of emotional expression, support is demonstrated by caring

for the physical needs of an individual. For this reason, an indirect approach to discussing emotions may be more effective in therapy (Sue & Sue, 2008).

Sue and Sue (2008) also observed that the integration between the mind, spirit, and matter and the balance of yin and yang are critical to health in Asian cultures. It is often believed that illness is a result of disharmony in these relationships. Ergo, the roles of the spiritual and of energy are paramount in understanding the perspectives on healing, which focus less of psychopathology in favor of stages of enlightenment and states of consciousness achieved through meditation. This belief system, in turn, creates a tendency to report emotional stress as a somatic problem, which is regarded as a more culturally acceptable way of seeking help for a psychological concern. This is also derived from the belief that it is the physical problem that causes the emotional distress, so that emotional problem will dissipate once the somatic symptom is healed (Sue & Sue, 2008).

Lee and Mock (2005), the contributors of the chapter on Chinese families in McGoldrick, Giordano, and Garcia-Preto's (2005) text, explain that mental health issues in Chinese culture may be derived from a vengeful spirit or negative karma for transgressions against the family, character weakness, tainted genetics, physical disorders, or physical or emotional strain and exhaustion. These issues may be treated with herbal medicine, acupuncture, therapeutic massage, ritual healing, Qigong, or improved nutrition (Lee & Mock, 2005).

Because there are some significant differences between the traditional Asian values and American values, Sue and Sue (2008) state that the process of acculturation can create a conflict of identity, as well as conflict between different generations of Asian American families. Children and young adults often feel pressure to fit in with their peers while also

needing to maintain the traditional values of their parents. This conflict can create psychological distress where the individual feels compelled to conform in each situation, but doesn't quite fit in with either group (Sue & Sue, 2008). Difficulty adjusting to America; culture shock; the effects of migration on the individual and on the family life cycle; acculturation issues; and family, work, and financial stresses could all contribute to psychological distress. However, community support and spiritual beliefs may provide assistance in coping with these stressors (Lee & Mock, 2005).

Lee and Mock (2005) assert that traditional Chinese Americans will first seek help for psychological distress within their families to avoid shame, guilt, and stigma. If the problem persists, community elders, indigenous healers, spiritual leaders, and physicians within the community may be consulted. Psychiatrists and other mental health clinicians are a last resort (Lee & Mock, 2005). If an Asian American does seek counseling, the process of psychotherapy may be unfamiliar to them. Sue and Sue (2008) suggest that the counselor describe his or her role and the role of the client, and then focus specifically on the presenting problem the individual complains of and develop specific goals that are solution-based. While the counselor may need to be more directive than usual, they should strive to encourage the client to be part of the process of developing their goals. The session may require the counselor to be active in structuring the session and generating choices, but the client can be aided in making his or her own decisions (Sue & Sue, 2008). Lee and Mock (2005) suggest conveying expertise through confidence; using self-disclosure, particularly about credentials and family background; actively engagement in problem-solving; using flexibility in the helping role assumed; demonstrating empathy and a willingness to concretely address and alleviate symptoms; establishing relationships with other family

members if agreed upon; working towards healthy dependence; and employing the cultural strengths of a client and their family.

While there are many distinctions between Western and Eastern methods of healing, Sue and Sue (2008) also identify some similarities between indigenous healing principles and Western ones. Both Shamans and psychotherapists/counselors require credibility of experience and training, have a shared worldview with the clients they serve, display compassion to their clients while also maintaining professional detachment, and utilize their expertise to get in touch with the spirits or unconscious that may be plaguing the client (Sue & Sue, 2008). In this way, commonalities between the two philosophies of healing can be presented.

Chinese Culture and Movement for Health and Healing

Ai (2006) describes Qigong, a component of traditional Chinese medicine, as an energy-based practice used to promote health through deep breathing and meditation integrated with movement. It can be thought of as the combination of two practices, an external practice of dynamic Qigong that strings together a set of slow movements and an internal practice of meditative Qigong that focuses on the control of breathing and is performed in a still position. Qigong is meant to be an ongoing practice that is incorporated into a person's lifestyle and strives to integrate the body, mind and spirit with each other and with society, nature, and the cosmos. Through this incorporation of the body and mind, it can be considered a psychosomatic practice that seeks to develop and enhance energy and spirit to achieve or maintain health. Overwhelming emotion can affect the energy balance

and cause physical illness, and Qigong is often used to stabilize the energy balance (Ai, 2006).

Cultural Issues in Diagnosis

In their content analysis, Lehti, Johansson, Bengs, Danielsson & Hammartröm (2010) confirmed a "Western Gaze" that was present in the writing of medical articles about depression. They found that "illness complaints, depression-related beliefs, norms, and behavior, and clinician–patient encounter…can be seen to be formed by different sociocultural, gendered, or religious power dimensions, which all influence diagnosing depression" (Lehti et al., 2010, p. 106). Some of these dimensions reported are distinction between the mental and physical, variance in the threshold of what is considered illness that requires treatment versus what is just a troublesome experience, and an extension of illness to include familial and communal suffering. Lehti et al. (2010) found that these cultural differences were not analyzed and accounted for in terms of the sociological impact they had on the clients, nor with the awareness that the differences were being viewed from a particular lens. Consequently, this Western gaze represents a bias that affects the diagnosis and assessment of clients with depression, particularly because these differences indicate that diagnostic tests are not universal and must be accommodated to account for different cultural contexts.

Kim and Chun (1993) confirm this influence of culture on diagnosis in their quantitative observational study. With a significance level of 0.05, they found that Asian females were more likely to be diagnosed with major depression or dysthymia and nonpsychiatric disorders (including academic and interpersonal problems, malingering, and

bereavement). Caucasian females, on the other hand, were move often diagnosed with adjustment or conduct disorders. Asian males were also more likely to be diagnosed with a nonpsychiatric diagnosis than their Caucasian counterparts, who more frequently received an affective diagnosis (bipolar disorder or cyclothymia). An increased rate of diagnosis with a nonpsychiatric disorder was the most significant difference overall between Asian and Caucasian clients, though these differences were more pronounced in females than in males. In general, Asian females were more frequently diagnosed with an affect-based disorder, whereas the Caucasian females were more often diagnosed with a behavioral-based disorder. Differences amongst Asian populations were also found, with Chinese and Japanese adolescents being diagnosed similarly to one another, but differently from the Korean and Vietnamese clients. As a product of these results, Kim and Chun (1993) recommend "increasing cultural sensitivity by hiring bicultural and/or bilingual staff, designing culturally sensitive assessment tools, and implementing therapeutic strategies that are consonant with the cultural norms of the population," (p. 616).

Variation in Depression Symptomatology

Waza, Graham, Zyzanski and Inoue (1999) tracked the reporting of somatic symptoms in Japanese and American clients. Their quantitative observational study (p-value < 0.05) discovered that both groups reported a significant amount of physical complaints, but the Japanese clients did so with a much higher frequency. Japanese clients were reported as having complained more frequently about each of the six somatic symptoms addressed, but with a higher variance in three specific symptoms: headaches, neck pain, and abdominal pain. These areas of the body have cultural significance in Japanese culture. For instance,

the abdomen is said to be the site of feeling and emotion. Complaints of fatigue, loss of appetite, and sleep problems were more evenly distributed between American and Japanese clients. Japanese clients reported solely physical symptoms three times as often as the American, whereas American clients reported solely psychological symptoms four times as often as the Japanese. While somatic and psychological symptoms were each present in both groups, the ratio of which type of symptoms takes precedence in each culture is revealing (Waza, Graham, Zyzanski & Inoue, 1999).

The presence of somatic symptoms has also been observed in Chinese mental health clients. Yen, Robins, and Lin (2000) examined depressive symptomatology for Chinese psychiatric outpatient clients; the general Chinese population; and Chinese, Chinese American, and Caucasian American students in their quantitative survey. They found that the Chinese psychiatric patients reported the highest number of somatic symptoms, but the Chinese students had the lowest. The Chinese American and Caucasian American students were situated in between. The authors used this to eliminate the variable that somatic symptoms are higher on average in the Chinese population, since the Chinese students reported the least somatic symptoms. Therefore, it shows a correlation between mental illness in China and the reporting of somatic symptoms. The authors offered a number of explanations, including the experience of depression in Chinese clients or a culturally acceptable process for help-seeking. Yen et al. (2000) also suggest stigmatization of mental illness and/or insufficient treatment for mental illness as possible explanations for the appearance of somatic symptoms in Chinese psychiatric patients when they were not found to be present in the general Chinese population (Yen, Robins, & Lin, 2000).

Nakao and Yano (2006) also explored somatic symptoms in their quantitative survey and interview study of Japanese adults with an n of 1027. They sought to test whether or not these symptoms were predictive of major depression in the following year and found that both lower back pain and dizziness were significant predictors with a p-value of <0.05. The authors assert that these findings present cause for the careful observation of somatic symptoms as a potential signal for major depression. They suggest physicians should be made aware of this correlation for the quick identification of depression in at-risk clients who report to their routine health examinations with these symptoms (Nakao & Yano, 2006).

Cultural Values Regarding Treatment and Help-Seeking

Fogel and Ford (2005) investigate this hypothesis of stigma in their quantitative Internet survey. They found that Asian Americans had greater stigma beliefs in regards to seeking mental health treatment than Caucasian Americans in all of three categories: friends, employers, and family. This remained true when the sexes of both groups were analyzed independently from one another. However, for survey participants under the age of 16, the Asian Americans only scored higher on stigma for the family category and not for the friend or employer categories. This may be attributed to the acculturation of the younger generations and American educational experiences that inform students of mental illness. Within the group of Asian Americans, males had a higher stigma than the females for friends and employers, but not for family. In this study, stigma was found to influence seeking mental health treatment (Fogel & Ford, 2005).

In another quantitative Internet survey, Wong, Kim, and Tran (2010) examined the relationships between adherence to Asian values, thoughts about the causes of depression,

and preferred coping strategies to handle illness. The Asian values measured included conformity to norms, family recognition through achievement, emotional self-control, collectivism, and humility. The researchers found that adherence to Asian values is a likely indicator of belief in an internal cause for depression, which then leads to coping through disengagement strategies, such as social withdrawal and self-criticism. Adherence to Asian values has a negative correlation to engagement coping strategies, which is problematic for seeking professional assistance and care. It is recommended that mental health providers receive training to understand the attribution of depression, the preferred methods of coping for Asian Americans, and to be respectful of these beliefs in treatment. Furthermore, it is suggested that counselors make a point to provide outreach services to the Asian American community (Wong, Kim, & Tran, 2010).

Givens, Houston, Van Voorhees, Ford, & Cooper (2007) explored the treatment preferences of ethnic minorities with depression in their quantitative Internet survey. They found that Asians and Pacific Islanders were less likely to believe that depression has a biological etiology and more likely to believe that antidepressants are addictive. They are also more likely to believe in the effectiveness of prayer or counseling over antidepressants for the treatment of depression. Out of the three minority groups, Asians and Pacific Islanders demonstrated the most concern about stigma**.** Asians and Pacific Islanders were also less likely than Caucasians to be interested in working with a clinician of the same ethnicity, which the researchers suggest could be a result of the stigma and consequential desire for social distancing (Givens, Houston, Van Voorhees, Ford, & Cooper, 2007).

Gonzalez, Tarraf, West, Chan, Miranda, and Leong (2010) inquired more specifically about the use of antidepressants in Asian Americans with depressive or anxiety disorders.

They discovered that antidepressant use among the Chinese, Vietnamese, and Filipino populations was significantly lower than Caucasians. Antidepressant usage was particularly low in the Filipino population, and the researchers warn against lumping together seemingly similar ethnic groups. These differences were not attributable to socio-economic or healthcare access factors, but it should be noted that acculturation and insurance coverage were influential factors on antidepressant use (Gonzalez, Tarraf, West, Chan, Miranda, & Leong, 2010).

Culturally Sensitive Depression Scales

Several studies have proposed culturally sensitive depression scales and treatment methods. Zane, Enomoto, and Chun (1994) were the first to examine mental health treatment outcomes for Asian Americans. This quantitative observational study investigated the effects of short-term individual psychotherapy for Asian and Caucasian Americans. After controlling for pretreatment severity of illness, social class, and individual attitudes of both therapist and patient, the researchers found that Asian Americans reported less satisfaction with their treatment on all five indices, as well as increased symptoms after treatment. Therapists also evaluated them as being lower-functioning than their Caucasian counterparts (Zane, Enomoto, & Chun, 1994).

Lam, Pepper, and Ryabchenko (2004) used both the Beck Depression Inventory (BDI) and also the Mood and Behavior Questionnaire (MBQ) in their quantitative survey and diagnostic interview study to re-evaluate the findings in earlier studies that Asian Americans are more likely to score higher than Caucasian Americans on checklists measuring psychological distress, yet score evenly on mood level in interviews**.** This study supported

those findings, revealing that Asian Americans tend to score significantly higher on the BDI, but are no more likely to be diagnosed with depression in diagnostic interviews. They did not score higher on the MBQ. These inflated scores on the BDI pose the concern that Asian Americans are likely to be over-diagnosed for mood disorders when they are evaluated using self-reported measures. This indicates that the methods with which we use to diagnose Caucasians, such as the BDI, are not culturally sensitive and may not be accurate in diagnosing Asian Americans. While the MBQ did not report a difference between Asian and Caucasian Americans in this study, it was found to give a significant false positive diagnosis of depression in both groups (Lam, Pepper, & Ryabchenko, 2004).

Hyun, Nam, Kang, and Reynolds (2009) tested the reliability of the Korean translation of the Reynolds Adolescent Depression Scale: Second Edition in their quantitative observational study. Though this scale was established as culturally appropriate for a South Korean population, it was validated for non-clinical, school-based adolescents. Further research with other populations is needed to expand the verification of this scale to other populations (Hyun, Nam, Kang, & Reynolds, 2009).

Koh, Chang, Fung, and Kee (2007) used a quantitative correlational study to construct and validate a Children's Depression Scale for a Singaporean population. This scale included constructs, such as negative affect, cognitive dysfunction, loss of interest, and psychosomatic manifestations, that had been validated internationally and proven to have robust relationships with depression. In addition to these, the researchers added what they termed "negative social self" to the scale, which represents additional symptoms pertaining to concern over interpersonal relationships. This factor was also found to be significant in

the diagnosis and meaning of depression in Singaporean children (Koh, Chang, Fung, & Kee, 2007).

Introduction to Dance/Movement Therapy

History of Dance/Movement Therapy

Levy (1988) states that dance has been used in various cultures throughout time for the purpose of emotional, spiritual, and physical release. In this way, it has a long history of being used as a catalyst for healing. It began to be formalized into the profession of dance/movement therapy (DMT) in the 1940's in America. This codification was made possible by the cultural environment of the time. One such element was the prominence of modern dance, which was critical to the development of DMT and had a particularly significant impact on its theoretical foundation. Modern dance calls for the emotional catharsis of the individual, moving away from the more rigid and virtuosic nature of ballet and the entertainment-oriented show dancing (Levy, 1988). This focus on the spontaneous and authentic expression of the individual led to a rediscovery of the healing capacity of dance (Bartenieff, 1975). Bartenieff (1975) states, "The great pioneers of [modern dance's] early years personified themes of human conflict, despair, frustration, and social crisis," (p. 246). This new emphasis on dance as the expressive catalyst for the individual and his or her unconscious paved the way for the introduction of dance interventions in mental health facilities (Levy, 1988).

The increase in nonverbal communication research and nonverbal treatment methods also influenced the cultural milieu and made way for a discipline such as DMT. Levy (1988) discusses the impact of the field of nonverbal communication:

> The flourishing of nonverbal communication research during this period benefited dance therapy significantly. It brought new recognition to the importance of body movement in psychotherapy. It also provided a recognized methodology and terminology for researching and observing the meaning of movement behavior and the interconnection between movement and emotional expression (p. 10).

In addition to this contribution of nonverbal communication, several prominent psychologists began integrating elements into their theories and practice that helped provide the context for the evolution of DMT. Among these were Carl Jung, whose theory of active imagination encouraged the use of creativity to awaken the unconscious, and Wilhelm Reich, who studied the interactions between the somatic and the psychic (Levy, 1988).

It was in the midst of this milieu that Marion Chace started the work that was to become dance/movement therapy. She had opened a dance school and was teaching classes when pediatricians and psychiatrists began referring their patients to her dance class. While working with these students, Chace became aware of the varying needs of different students and began using empathic reflection as a technique in working with them (Chace, 1993). She was then invited to work at St. Elizabeth's Hospital in Washington D.C., a federal psychiatric hospital. It was here that she began her foundational work, referred to as a "dance for communication" program, which would later become DMT. Psychotropic drugs had not yet been introduced, and treatment methods were still actively being sought and explored. This left an openness that encouraged exploring various modes of therapy and treatment options. To address the psychological troubles of the influx of veterans returning from World War II, Chace began to lead sessions for the veterans. Chace began working with individuals at the hospital who were suffering from a wide variety of issues, including those who were

schizophrenic, depressed, manic, withdrawn, overactive, hostile, and those who exhibited other psychoses or were in the closed wards (Chace, 1993).

Eventually, Chace began to take interns and offer workshops about her work at St. Elizabeth's (Chace, 1993). Co-workers, therapists, and students began to train under her and spread dance therapy to other institutions and clinics (Levy, 1988). In 1966, the American Dance Therapy Association (ADTA) was founded, and Marian Chace served as president for its first two years. This development led to the institutionalization of the field and the regulation of standards for the profession (Chaiklin, 2009).

Dance/movement therapy is defined by the American Dance Therapy Association (ADTA) as "the psychotherpeutic use of movement to promote the emotional, cognitive, physical, and social integration of individuals." (ADTA, 2009) It is founded on the belief that the body and mind are inherently interrelated and affect one another. More specifically, it asserts that the emotional state of an individual is communicated in his or her body movement. In turn, altering the pattern of movement behavior can affect change on the emotional state and can contribute to well-being (Levy, 1988). Today, there are dance/movement therapists serving clients all over the United States and in over 30 other countries around the world (ADTA, 2009). Although the concept of dance as a healing tool is seen in many cultures, it is important to note that the professional development of DMT taught and practiced in the United States evolved from primarily Western styles of dance and Western psychological theories and models.

One Western influence that is foundational to dance/movement therapy is Laban Movement Analysis, which is the framework used to observe and analyze movement in the field. This system of movement observation is complex and multifaceted. It accounts for

both the expressive and adaptive aspects of movement (North, 1972). While it is beyond the scope of this study to fully review this framework, I will give a brief overview of the main categories of which it is composed. The four overarching categories in Laban Movement Analysis are Body, Shape, Space, and Effort. The Effort category, which refers to the quality of the movement, is the most emphasized in dance/movement therapy. North (1972) states, "it is the inter-related movement patterns and rhythm which reveal personality traits," (p. 18). There are four subcategories of Effort Qualities, which include Space, Weight, Time, and Flow. The Effort of Space corresponds with attention, thinking, and cognition. An individual can have either a Direct or Indirect approach to Space. A Strong or Light attitude toward Weight is representative of an individual's intention, will-power, and sensation. A Sudden or Sustained approach to the Effort of Time may indicate the style of an individual's decisiveness and intuition. A Free or Bound attitude toward the Flow Effort represents an individual's approach to precision, emotions, and relationships (North, 1972). These Effort Qualities are one source of information that dance/movement therapists use to assess individuals and to create interventions.

One way dance/movement therapists use the Effort Qualities in their work with clients is by "picking up" on and mirroring an individual's pattern of Efforts, which is otherwise known as empathic reflection (Sandel, 1993). Empathic reflection is a foundational technique in dance/movement therapy and is used to develop trust in the therapeutic relationship, communicate understanding and support, and foster growth and openness. It requires the therapist to be attuned to the state of the client and to be flexible in response to the verbal and nonverbal communication conveyed by the client (Sandel, 1993).

Chaiklin and Schmais (1993) culled the themes present in some of Marian Chace's papers to propose the core concepts of Chace's approach to DMT. They list four concepts as the emphasis of her work, which include Body Action, Symbolism, Therapeutic Movement Relationship, and Rhythmic Group Activity. Body Action refers to the use of the body to promote health through integrating adaptive movement and psychic attitudes, thereby preparing the individual for emotional expression. The role of Symbolism is to promote communication, particularly through the use of movement that evokes a client's experiences or correlates with their feelings. The Therapeutic Movement Relationship helps to develop trust by reflecting the emotional content of the client's movement to convey understanding. Rhythmic Group Activity encourages organization, group cohesion, and a sense of strength and security. The dance/movement therapy session begins with the therapist assessing the climate of the group or individual to determine the appropriate nature for the warm-up. This first section of the session is meant to simultaneously warm up the body through movement and open the mind for emotional expression and social interaction. The therapist expands on elements of movement that the clients provide and uses these elements to develop the session improvisationally, based on the needs of the group in the moment. The session then transitions into the theme development section, which focuses on a few of the themes that emerged from the warm-up. This theme is explored to promote growth, development, and expression of feelings around the subject. In addition to the movement intervention, imagery and other verbalizations may also be used. The final section of the dance/movement therapy session is closure, which is used to resolve the work of the session and return the clients to a state of stability while fostering a sense of well-being and community. While this is a commonly used format, the structure of the dance/movement therapy session also varies in

reaction to the clients' needs and responses. It can take the form of specific structured tasks or gravitate more toward spontaneous improvisation depending on the clients (Johnson, et al, 1983; Meekums, 2002).

Dance/Movement Therapy for Depression

The field of dance/movement therapy (DMT) itself has limited research that explores the efficacy of its treatment approach on people with depression. Consequently, this section will broaden its scope to include research from several related fields, including music therapy, aerobic dance, exercise training, and mindful and non-mindful exercise, from which some information may be extrapolated to speak generally to the potential of DMT.

Cruz and Sabers (1998) revised a quantitative meta-analysis completed by Ritter and Low (1996) on the effectiveness of DMT for various populations. It was found that DMT interventions are more effective than was previously claimed. Moreover, Cruz and Sabers (1998) further report that DMT is as effective as other psychotherapies and medical treatment modalities. Despite the importance of this finding, Ritter and Low (1996) state that many of the studies done on DMT are non-quantitative and poorly controlled. So, it is necessary for dance/movement therapists to continue to put forth thorough research to better understand its effectiveness for specific populations.

One study Ritter and Low (1996) cited is particularly relevant to this study. Brooks and Stark (1989) conducted an experimental pilot study to measure the change in affect of both hospitalized and non-hospitalized participants after a DMT intervention. The study measured changes in anxiety, depression, and hostility based on affect and found that there was no significant difference between the changes of the hospitalized versus non-hospitalized

groups. However, all participants in the DMT groups, as compared with the control groups, demonstrated a significant decrease in depression and anxiety scores. This provides preliminary evidence that DMT sessions can improve affect in both hospitalized and non-hospitalized participants. This study's limitations were that the authors did not control for all variables and that their was only one DMT session, so further studies should be conducted to explore the effects of a course of dance/movement therapy sessions (Brooks & Stark, 1989).

In an experimental study, Jeong, Hong, Lee, Park, Kim, and Suh (2005) investigated the impact of a 12-week course of three weekly DMT sessions on a group of adolescent Korean females with mild depression. They found that DMT may stabilize the sympathetic nervous system in this population, as demonstrated by an increase in plasma serotonin concentrations and decreased dopamine concentration. The DMT group also demonstrated improvement in all negative symptoms measured, including dimensions of somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, psychoticism, while the control group's negative symptoms increased slightly. Further research should be conducted with a larger sample size, an exercise control group, and long-term follow-up (Jeong et al, 2005).

In a systematic literature analysis, Ernst, Rand, and Stevinson (1998) examined the effectiveness of various complementary therapies, including DMT, for the treatment of depression. While the two studies on DMT did demonstrate a decrease in depressive symptoms for some participants, both studies have methodological shortcomings. Therefore, these shortcomings and the limited number of studies lead to insufficient evidence to assess the effectiveness of DMT as an intervention for depression. Other related complementary therapies studied, such as music therapy and relaxation therapies, also show potential, but

require further research to provide sufficient evidence. Moreover, any type of exercise was found to be as effective as psychotherapy in improving depressive symptoms, though the many studies that investigate exercise's impact on depression also have methodological significant limitations (Ernst, Rand, and Stevinson, 1998). Because DMT incorporates physical exercise along with psychotherapeutic techniques, the promise of exercise as a treatment for depression may provide convincing evidence for the continued pursuit of research for dance/movement therapy.

Koch, Morlinghaus, and Fuchs (2007) conducted an experimental study to compare the effectiveness of a circle dance with jumping rhythms (movement and music) on depression as compared to just music or just movement (ergometer). The researchers report a significant decrease in depression for members of the dance group, with no change in the other two groups. Vitality and affect improved from pre-test to post-test in all conditions, though members of the dance group showed a significantly higher increase in vitality as compared to the music group, but there was no between group difference in change of affect. In the dance group, there was an increase in motivation, coping, strength, energy, and enjoyment from the pre-test to the post-test, while depression, lifelessness, anxiety, tension, and tiredness all showed a decrease. When asking the participants which therapies had helped them the most so far, the creative arts therapies were named 32 times (17 movement, 11 music, and 4 art), as compared to 12 mentions of occupational therapy, 11 for talk therapy, 7 for behavior groups, 3 for activities in the open (jogging and walking), and twice for meditation and massage. This perceived benefit reported by participants may encourage increased adherence to treatment. Limitations of the study include small sample size, brevity of intervention, and the participation of the researchers as the dance/movement therapists.

Research on other movement modalities for depression may also be applicable, particularly when they include an integrated attention to the mind as well as the body. Tsang, Chan, and Cheung (2008) conducted a meta-analysis of randomized, controlled trials that researched the effects of mindful or non-mindful exercises on depression. The mindful exercises included qigong, yoga, and tai chi, while the non-mindful exercises included aerobic exercise, walking, and jogging. They found that overall, physical exercise has a positive effect on alleviating depressive symptoms for various populations and can be as effective as medication. The mindful exercise studies were all found to be beneficial in treating depression and five of the non-mindful exercises also had positive results. Because of methodological limitations of the studies evaluated, no comparison between the mindful and non-mindful exercises could be made at the time (Tsang, Chan, & Cheung, 2008).

Creative Arts Therapies and Culture

The literature addressing multicultural issues in the creative arts therapies has grown exponentially in recent years. While it is beyond the scope of this study to review the entirety of this subject, a sampling of the range of topics being explored is provided. Articles have been written on multicultural considerations for various modalities, including the role of poetry therapy in raising awareness of racism (Stepakoff, 1997), ethical considerations in multicultural therapy for music therapists (Bradt, 1997), using an anthropological understanding of cultural patterns to improve dance/movement therapy theory (Hanna, 1990), and the influence of culture on the process of art therapy with children (Malchiodi, 2005). Research has also been conducted on using the dance/movement therapy with various populations, including DMT for Latinos (Madrigal, 2002), for dementia in Japanese clients

(Arawaka-Davies, 1997), for at-risk African American adolescents (Farr, 1997), for empowering women (Gordon-Giles and Zidan, 2009), for people transitioning genders (Hanan, 2010), for social interaction using Irish dance (Draper, 2009), for war-affected refugee children in Serbia (Singer, 2006), for adolescent African torture survivors (Allan Harris, 2007), for exploring ethnic identity with Korean American young adults (Shim, 2003), and for acculturation and nonverbal interaction patterns with Chinese American immigrant parents and their children (Duh, 2008). Numerous studies have also been conducted about the interface of dance and culture (Bartenieff and Lewis, 1980; Boas, 2006; Cooper Albright, 2001; Dixon-Gottschild, 1996; Desmond, 1997; Eddy, 2002; Hanna, 1979; Katz, 1982; Moore and Yamamoto, 1998; and Knapp and Hall, 2002). The research included below includes several theoretical articles on the role of culture in the creative arts and then more specifically considering DMT with Asian American clients. Next, specific studies that use creative arts modalities with various Asian and Asian American populations are reviewed.

Aldridge (1996) emphasizes the influence of culture on illness and treatment, as well as the role of the creative arts attending to these considerations. He describes the body as a locus for inscribing the social and the point where the internal and external merge and interact. He asserts that because the body is an indication of our health, the diagnosis of a medical issue becomes part of an individual's identity, along with any stigma that may be attached to that diagnosis. The identity a person creates is representative of how they address their problems and indicates what type of treatment they are likely to seek. For example, the author states that the layperson uses their experience of mood and vitality to evaluate their health. Yet, our culture's rigid epidemiological and empirical values may not leave room for

other forms of treatment that the individual feels is relevant, or account for the healing properties of eating, dancing, singing, and spending time outside while with loved ones. The author states that the role of fun and leisure in health has yet to be studied, but support the impact of positive emotions in improving health. He contests the paradigm of Cartesian dualism and asserts that the axiom, "I perform, therefore I am" is more germane to human condition because learning is through experience and doing with the body, rather than thinking. He gives the example that one does not learn to swim by reading or hearing a lecture, but by having the body experience the sensation in the water. This is why the expressive arts are so powerful; they emphasize the lived body and are therefore closer to the physical symptoms. Furthermore, they acknowledge that the body is not only heard, but also sensed. The expressive arts can represent the uniqueness of an individual's illness and circumstances, whereas the current attempts to plot illness on graphs assumes that we are all able to be measure accurately and hence that our inner realities are standardized. They can also lead to development of the individual and through improvisation, an increased repertoire for adaptation. Aldridge (1996) claims that if we want our clients to make changes to address their illness, we have to be aware of the link between the illness and their identity, as well as the culture and people who validate that identity and the impact that change will have.

Henderson and Gladding (1998) assert that the creative arts are influential in the rehabilitation of mental illness across cultures. They name eight areas where the creative arts can make a unique contribution with each citing an account showing how it has been done. The first offering is promoting self-esteem and self-awareness through the symbolic expression of the creative arts. Next, the authors encourage the use of culturally relevant

metaphors to heighten the therapeutic process. The creative arts are then credited with imparting concrete experiences to clients that they are able to call upon to assist them in relating to others. In addition, they also help develop new ideas and interests to expand awareness. The experiences with the creative arts can provide understanding that helps individuals tie together their past, present and future, as well as bring recognition and value to the beauty and wisdom that their cultural background offers. The positive feelings that are generated from the creative arts can be recalled to celebrate good times, but also to cope with trying times. Finally, the authors state that the creative arts can foster hope, confidence, and insight to encourage the individual to live a fulfilling life. The authors emphasize that the creative arts are capable of all these contributions to help unify and strengthen a community. The arts are a tool that help build therapeutic rapport and that provide a universal medium for the expression and appreciation of cultural differences, and can utilize cultural strengths, all essential components of multicultural counseling (Henderson & Gladding, 1998).

The theoretical support for the use of the creative arts as a means of addressing cultural issues in mental health is reinforced by Kim's (2009) report that there is an increased demand for art therapy in Korea. She calls for increased professional development of the field internationally through collaboration. Korean students came to the United States in the mid 1990's to study art therapy and bring it back to Korea. As of 2008, 29 educational programs (at the graduate and undergraduate levels) and seven local and national art therapy associations have developed in Korea. The author also discusses seminars and workshops given in Korea and mentions the attention given to cultural differences. The differences in violence and conflict because of the lack of guns in Korea is used as an example. The number of clinics and institutions where art therapy is available has increased, but lack of

standardized criteria to practice as an art therapist is one of the primary struggles that the profession has yet to overcome in Korea. The author suggests comparing the similarities and differences present in art therapy across different countries to make suggestions for improvement and increase interaction and exchange of information, all while considering the varying dynamics of the health care systems in different cultures (Kim, 2009).

Dosamantes-Beaudry has written several articles on culture and DMT. She discusses dance therapists' search for alternate treatment methods starting in the 1980's to address the increased need to serve ethnic minorities and as a response to dissatisfaction with the medical model of psychiatry (Dosamantes-Beaudry, 1997a). However, the author states that this search led to the appropriation of ethnic healing practices in some cases, which can have significant ethical consequences. At this time, the author also comments that dancers and body-oriented psychotherapists from many different countries became interested in the methods of American dance therapists, and it began to spread internationally. Dosamantes-Beaudry comments on the uncertainty of how DMT will evolve in these various cultural settings and blend to meet the needs of these different countries (1997a).

In another article, Dosamantes-Beaudry (1999) explores the differences between 20-25 self-selected Western European and Taiwanese women who were dance and mental health professionals at workshops on American DMT that she conducted. She approaches the article using the framework of a cultural self-construal, or the subjective view persons hold about who they are and how that anchors their worldview. The participants were asked to think about how they experience themselves and then offer a movement or gesture about how they were feeling. She observed that the Western European participants expressed a wide variety of emotions, both positive and negative, verbally and in movement with little

hesitation, and that there was a considerable diversity amongst individual movements. At the Taiwanese workshop, participants demonstrated considerable hesitation about expressing their feelings publicly. The movements offered were often a slight variation of previous participants' movements and expressed primarily positive emotions with an affinity for humor. Dosamantes-Beaudry (1999) reported being regarded as a teacher, with participants granting her respect and being particularly attentive to her needs. The author attributes these differences to individualist and collectivist perspectives. Individualists belong to a culture that views the expression of emotions as acceptable, healthy, and mature and respect uniqueness and independence. Collectivist cultures tend to value fitting in with others and view the inhibition of feelings as mature. It is seen as respectful and modest to avoid standing out. Dosamantes-Beaudry states that the nature of the exercise she led corresponds with the individualist paradigm, which explains the hesitancy of the Taiwanese participants and the comfort of the Western Europeans to the exercise. She suggests that it is critical for a therapist to be alert to differing responses to their prompts and to attune to the worldview of a group. It is also noted that exposure to various cultures can create a hybridized cultural self-construal, which may incorporate elements from both the individualist and the collectivist patterns. As therapists respond to the need to make their interventions compatible with varying cultural worldviews, hybridized versions of DMT theories will begin to emerge (Dosamantes-Beaudry, 1999).

Chang (2006) conducted a workshop based on a previous ethnographic case study to increase dance therapists' cultural sensitivity by examining culture, ethnicity, and race during the DMT process. Her results fit into three categories: individual self-perception, educational systems, and socio-cultural context. The first category, individual self-perception,

encompasses similarities between Korean, European, and American students, which include the desire to study DMT, an interest in self-discovery, and a distinct kinesthetic identity that is valued by and unique to the individual. Conversely, the American educational process of DMT was not viewed as being culturally congruent by the Korean students, who found the student-centered approach distressing because of the verbal self-disclosure required and the more active role of the student in finding their own answers. The Korean students also reported that American DMT education was more focused on the science than the art, with emphasis on psychology rather than on dance. The socio-cultural implications of the results show that the cultural habitus, or the culturally acquired schemata of a group, of Korean DMT students prefer interventions that utilize ritual or shamanic dance forms. The author also suggests that teachers of DMT to Korean students should learn the language and the history to better understand the core beliefs and context of the culture in which they are teaching (Chang, 2006).

Later, Chang (2009) writes about the global context of DMT. She proposes that for dance therapy to be effective in a multicultural context, attention needs to be given to three practices. The first is dance therapists' development of self-awareness of their racial, ethnic, cultural, gender, and class background. Next is the development of culturally congruent dance therapy theories and models, including a reflexive relationship between therapist and client regarding their cultural and political contexts. Finally, Chang (2009) calls for mutuality in the therapist/client relationship when determining the in the significance and interpretation of movement aesthetics and interactions, particularly in relation to assessment and diagnosis. She also suggests having a native of the culture self-identify as a cultural informant to help translate for the therapist (Chang, 2009).

Pallaro (1997) posits that DMT is well suited to treating clients of diverse culture backgrounds and cites her experiences working with Asian Americans as evidence. She states that DMT is particularly effective with Asian Americans when using an object relations theory and Jungian psychology framework because of their focus on the individual as well as the external influence of others. Pallaro (1997) claims that DMT provides a space for Asian American clients to explore and embody different levels of the self, which allows them to integrate the opposing messages of two different cultures through merging and differentiating. This eases the process of reconciling a complex cultural self-identity (Pallaro, 1997).

Linden (1997) conducted a case study with a Japanese/Korean-American woman in a Transformational Theatre/Drama Therapy and Sound Healing program, which involved in-depth Jungian-based therapy using the following techniques: classical psychodrama, other forms of drama therapy, sound healing, expressive movement, journal writing, meditation, visualization, breath and energy centers, and techniques with the intuitive arts. The program concludes with a performance piece focusing on life issues and the transformation of the participant. The author made a number of discoveries about cultural norms that were necessary to consider in order to treat her participant effectively. She found that it was not within the participant's cultural norm to divulge intimate feelings, particularly about potentially dishonorable family issues, and that consequently, feelings of anger are discouraged and were expected to be replaced by a requisite appearance of contentment, even in the face of conflict or pain. This reflects the emphasis on interdependence, obedience, and the fear of an individual's misconduct being exposed. Pressure to conform maintains the family's image and avoids shame. There is also an expectation for problems to be kept within

the family and solved there. An individual is expected to sacrifice for the good of the whole family, and, by enduring hardship, demonstrates loyalty. This was seen in the participant's reticence to open up and share. She initially expressed discomfort with expressing personal issues, but eventually was able to work through her conflict with the help of the group. The author found that her transpersonal/spiritual orientation was useful in building trust and forming a connection to the emotional work that was less familiar for the participant. She attributes this to the participant's Buddhist background and her comfort with exercises that involved awareness of breath, visualization, voice, and movement. The group nature of the therapy was also useful in addressing the collectivist orientation of the participant's culture. The author asserts that because she was also enacting other participants' dreams and memories, she became more comfortable expressing her own, which eventually supported her in expressing the identity of a "lone gypsy wandering alone." Another cultural norm that the author found relates to communication and relational style. She mentions that individuals must regard a person in a position of authority with affections, respect, gratitude, and obedience, and that communication should be indirect in nature to avoid confrontation (Linden, 1997).

Sakiyama and Koch (1997) explore the use of touch with patients with schizophrenia in a dance therapy session within the cultural context of Japanese society. They found that the dance therapy provides an environment that allows for the physical closeness of and use of touch with individuals. They assert that in Japanese culture, touch is culturally learned as a customary way of interacting and is representative of health. Fellowship with and reliance on other members of the group is created with the use of touch and facilitates the critical integration of the mind and the body. In this Japanese DMT session, the goals emphasize

social interconnectedness, whereas the authors state the primary emphasis of goals in a Western DMT session would be independence. A rhythmic component to the touch used in the session is significant and emphasized by the authors (Sakiyama & Koch, 1997).

Ho (2005) conducted a quantitative study with 22 Chinese cancer patients using a pre- and post-test study design with an intervention of weekly 90-minute DMT sessions over the span of six weeks. She sought to examine the impact of a course of DMT on the stress level and self-esteem of the participants. A program evaluation at the end of the intervention found that participants perceived the DMT sessions as helping them increase confidence, gain support from others, and learn more about rehabilitation. Most of the participants felt more happy and relaxed, as well as less stressed. The author identified four emergent themes, which included relaxation, mind-body interaction, personal growth, and spirituality. The author utilized an incremental approach to movement, beginning with relaxation and instruction of specific steps and eventually moved towards improvisation. This approach was found to be agreeable to the participants, which Ho (2005) attributes to an emphasis in Chinese culture to be disciplined and controlled with both physical movements and emotional expression. Limitations included a small sample size and short duration of intervention and observation, which could influence the measurement of self-esteem since it is a variable that requires more time to change and develop (Ho, 2005).

Tepayayone (2004) explored how culture can affect the clinical assessment of movement by dance/movement therapists in her phenomenological master's thesis. She first asked how dance/movement therapists perceived movement of people with a different cultural background, and four motifs were found in the observers' interviews. These include a belief that movement qualities of a mover should be compared within their own culture, a

likeliness for each culture to elicit particular images about dance, a need to have information about the context of a dance to understand the movement, and an awareness of the observers' own cultural backgrounds and experiences. Her second question explores the impact of the observers' cultural background on their experiences while observing, assessing, and interpreting the movers' movements. Six themes emerged from the observers' experiences, including difficulty rating the movement, being affected by a preconceived image of the ethnicity and race while perceiving the movement, having an emotional response while rating the movement, acknowledging that there are many factors that influence assessment of movement, knowing one's own experiences impact the observers' cultural awareness and sensitivity, and recognizing that differences exist within ethnic groups, as well as across them. Limitations of this study include small sample size and the use of a culturally based movement assessment instrument (Tepayayone, 2004).

CHAPTER 3: METHODOLOGY

Design of the Study

This is a qualitative case study that describes how an Asian American client with depressive symptoms responded to dance/movement therapy (DMT) and the form that DMT took during her therapy. This study involved a brief course of DMT and the collection of five forms of data. These include notes from the initial interview, the researcher's notes from each session, the participant's journaling from each session, transcription from discussions between the researcher and participant following each session, and a final interview. This design is fitting because the researcher seeks to explore the ways in which DMT may serve as a culturally congruent approach to therapy for Asian Americans with depressive symptoms and endeavors to understand the uniqueness and commonality of the individual and her personal stories in detail (Stake, 1995). The study also includes a cross-cultural therapeutic relationship, as the therapist/researcher is a Caucasian female who was born and raised in the United States.

Location of the Study

The study took place at a holistic healthcare center in Philadelphia, Pennsylvania. The facility has an orientation toward integrating Eastern and Western treatment approaches and many of its clients are Asian Americans. It offers a range of outpatient integrative services to treat both physical and psychological problems. The center also provides individual, group, couple, and family outpatient verbal psychotherapy services, creative arts therapies, stress management classes, nutrition and supplement counseling, Traditional Chinese Medicine treatments (acupuncture, Chinese herbology, acupressure), yoga, and tai

chi classes. Its mission is "to promote quality, affordable, integrative holistic healthcare services to all ages, cultures, ethnicities, and socio-economic levels." This site was chosen because it has a significant base of Asian American clients who were likely to fit the inclusion and exclusion criteria. The site could also offer additional support and referral services to the participant in the event of a problem.

Time Period for the Study

The study took place from April, 2011- May, 2012, following IRB approval of the study.

Enrollment Information

The study enrolled one participant. The participant was an Asian American female with depressive symptoms and was between the ages of eighteen to sixty-five. There were no exclusions based on gender or class.

Participant Type

The participant was an outpatient at a holistic healthcare center who was experiencing depressive symptoms and was of Asian descent.

Participant Source

The participant was recruited from a holistic healthcare center located in Philadelphia, Pennsylvania.

Recruitment

Recruitment began following IRB approval. The researcher provided the director of the recruitment location, who assesses all clients served by the center, with the inclusion and exclusion criteria for participation in the study. The director screened clients for eligibility. Eligibility criteria include exclusions for self-injurious behavior, plans for self-harm, or suicidal ideation, and psychosis. She notified those clients who met participation criteria about the research and their eligibility to participate. She then provided them with a Study Recruitment Flyer (Appendix A) and informed them that if they were interested, they could contact the researcher through the study specific email address or phone number listed on the flyer to obtain more information. The prospective participant initiated the first contact with the researcher. The researcher responded with a scripted email response (see Appendix B) to set up a phone conversation (Phone Recruitment Script, Appendix C) in order to briefly review study information, answer initial questions, and to arrange a meeting with the client. In the initial meeting, the researcher further described the study, confirmed the prospective participant's eligibility to participate, and confirmed interest and availability of the participant. The informed consent process was completed during this meeting.

Participant Inclusion Criteria

1. Individual was currently experiencing three or more of the following depressive symptoms: feelings of sadness or emptiness; fatigue or noticeable loss of energy; slowed responses or agitation; weight gain or loss or change in appetite; difficulty sleeping or sleeping too much; muscle tensions; bodily pain (including but not limited to abdominal distress, headaches, and neck pain); loss of interest or pleasure in

activities they used to enjoy; feelings of worthlessness or guilt; difficulty in thinking, concentrating, making decisions, or remembering; feelings of hopelessness.

2. Individual was of Asian descent and was living in the United States.
3. Individual was a current client at the recruitment location and had been receiving services for at least 6 weeks.
4. Individual was able to function in his or her usual school, work and/or family roles.
5. Individual had basic proficiency in English (reading, writing, and speaking).
6. Individual was between eighteen and sixty-five years of age.

Participant Exclusion Criteria

1. Individual had a diagnosis of psychosis, dementia, or mental retardation.
2. Individual had self-injurious behavior, plans for self-harm, or suicidal ideation.
3. Individual had a significant physical disability or current limitation that prevented participation in mild movement activity.

Investigative Methods and Procedures

Instrumentation

No standardized instruments were used in this study.

Researcher Reflexive Procedure (1 hour)

Prior to meeting with the participants and data collection, the researcher engaged in an independent reflexive procedure. This included journaling about possible biases and countertransferences, methods to separate her role as both therapist and researcher, and how her expectations about the research might affect what findings she sees and how she may interpret them as part of this process. Mertens (2005) describes the need for the researcher to have a keen self-awareness when conducting research to give context to the subjectivity of the work. This procedure allowed for increased validity and reliability in this research.

The researcher also engaged in a movement reflexive procedure. Chang (2006) describes the benefit of investigating cultural experience through movement:

> Autobiographical dance investigations demonstrated the ways that norms of emotional expression are specific to each culture. Such kinesthetic information can serve as a reference point for interactions with patients from other cultures and races. Just as self-knowledge of movement propensities helps the dance/movement therapist adjust her movement to become synchronous with the patient's in dance therapy, externalizing one's own racial, cultural, and ethnic habitus develops psychological awareness. By bringing the psychological habitus to consciousness, the dance therapist has a frame of reference for unfamiliar behaviors or movement patterns that the client presents…Workshop participants agreed with the concept that once the

> therapist identified the roots of his or her own cultural stance, the development of a culturally congruent practice was more likely to occur (p. 194, 203).

Because the researcher engaged with the participant on both verbal and nonverbal levels of communication, engaging in a reflexive process in both modalities was critical to bring awareness to both levels of interaction and thereby preparing the researcher more thoroughly to conduct the research.

Informed Consent (15 minutes estimated)

The consenting process took place in a private room at the recruitment center during the first meeting, scheduled at the convenience of the participant and the availability of the researcher. Fifteen minutes was the time estimated for the consenting process, but the participant was notified that she may have as much time as needed to read and sign the form. The researcher provided the consent document (Appendix D) for the participant to read and was available to answer questions. This form explained the purpose and procedure of the study, as well as outlined the rights of the participant and the responsibilities of the researcher. The participant was alerted that taking part in the study was entirely her decision and that she could terminate her participation at any point during the study without repercussion. Risks were identified as well as precautions to minimize these risks. Two consent forms were brought to the meeting, one for the participant to sign and keep for her records, and the other to be signed and stored by the principle investigator in a locked, secure file in the Department of Creative Arts Therapies. The participant had the opportunity to ask questions and then was asked to explain her role and rights in the research study, as she understood it. The participant demonstrated understanding of study

procedure and participant rights, confirmed meeting the participation criteria, was interested in study participation, and was asked to sign the two consent forms and initial each page. The researcher also signed each form.

Procedure

The research procedure involved an initial interview, three dance/movement therapy sessions followed by post-session journaling and discussion, and a final interview. The procedures are detailed as follows:

Meeting 1 (Total time following consent, 65 minutes).

Initial interview (20 minutes).

This interview took place between the researcher and the participant directly following the consenting process. The interview proceeded in accordance with the researcher designed initial interview guide (Appendix F). The purpose of this interview was to gather information relevant to the study with regard to the participant's history, cultural affiliation and practices, perspectives on mental health, history of symptoms, stresses and coping resources, and past therapy and movement experiences. The participant was asked what help she felt she needed, what she had tried before, what had been helpful and what had not, and what factors she would like to be taken into consideration regarding the DMT sessions. The researcher recorded the information in writing on the interview guide, which was coded with the participant's assigned PIN #. The interview process served to begin to establish a relationship with the client prior to the DMT sessions. The information gathered in the interview also served to help shape the DMT sessions by

guiding the selection of movement methods that met the participant's interests and needs. Relevant information gathered from the interview was summarized in the research to provide perspective and provide the researcher with comprehensive information about the participant's characteristics and experiences to account for diversity and context in the results.

Dance/movement therapy session (30 minutes).

The researcher facilitated an individual DMT session. During the first session, the participant was oriented to participation. She was told that she did not need any prior experience with dance or expressive movement and that it is common to experience some initial expressive self-consciousness. The movement session followed a classic DMT session structure with a warm-up, theme development, and closure (Chaiklin & Schmais, 1979). Dance/movement therapy is an expressive and relationship-oriented therapeutic process that is improvisational in nature. The researcher utilized the movement cues and verbal responses of the participant within the context of the therapeutic relationship and the movement process to shape the development of the session. She attended to the participant's level of comfort, mood, and other considerations in order to meet the participant and respond to her needs and preferences that arose during the session.

The session began with a body warm-up, which involved gentle movement that moved systematically through the body (flexing, extending or rotating joints, stretching muscles, engaging center of gravity in torso) to prepare the participant physically and psychologically for the rest of the session. The researcher also used this warm-up to get an

initial sense of the emotional state of the participant. The session proceeded into theme development based on the present needs and experiences of the previous sessions.

In the theme development portion of the session, the researcher/therapist used standard DMT methods, including body-based activities, improvised expressive movement, and structured movement tasks relevant to emerging issues. The researcher/therapist encouraged verbalization during the session in order to support identification, exploration, and integration of feelings and issues that arose during the session with respect for the participant's willingness and interest in doing so.

At the conclusion of the session, the researcher facilitated closure. The closure involved a physical cool-down with relaxing movement and a verbal discussion that summarized important themes from the session to re-establish physical and mental equilibrium (Chaiklin & Schmais, 1979).

Post session journaling and discussion (15 minutes).

Following the movement process, there was time set aside for the participant to reflect on the DMT experience through a semi-structured journaling exercise (Appendix G) while the researcher also reflected on her experience (Appendix H). The participant and researcher briefly discussed the written journal entries. The discussion was audio-recorded for transcription purposes.

Meetings 2 & 3 (Total time each meeting, 60 minutes).

Meetings 2 & 3 engaged the participant in additional movement sessions followed by post session journaling and discussion. The format and methods for these study activities were the same as in Meeting 1.

Dance/movement therapy session (45 minutes each meeting).

The researcher facilitated an individual DMT session in each meeting. The DMT sessions followed a classic dance/movement therapy session structure with a warm-up, theme development, and closure. The researcher/therapist utilized the movement cues and verbal responses of the participant within the context of the therapeutic relationship and the movement process to shape the development of the session. She attended to the participant's level of comfort, mood, and other considerations in order to meet the participant and respond to the needs and preferences that arose in the session.

Post session journaling and discussion (15 minutes each meeting).

Following the movement process, as in the first meeting, there was time set aside for the participant to reflect on the DMT experience through a semi-structured journaling exercise (Appendix G) while the researcher also took notes on her experience of the session (Appendix H). The participant and researcher briefly discussed the written journal entries. The discussion was audio-recorded for transcription purposes.

Meeting 4 (30 minutes).

Final interview.

At the end of the fourth meeting the researcher scheduled a time for the final interview to take place as an in-person or phone meeting according to the preference of the participant. In the final interview (Final Interview Guide, Appendix I) the researcher asked the participant questions about her experiences with the dance/movement therapy process, what was helpful or meaningful and what was not, the status of her depressive symptoms, and the participant's general response to DMT. The participant was also encouraged to add additional information she considered relevant and to ask any further questions she may have had about her experiences. This interview was audio-recorded for the purposes of transcription.

Data Collection

Participant Contact and Coding Form

The researcher entered the participant's name, an assigned participant identification number (PIN), email address, phone number, and scheduling information in a Participant Contact and Coding Form (Appendix E). This form was stored separately from all other data in a secure location and shredded at the end of data collection.

Initial Interview

An Initial Interview Guide (Appendix F) provided an outline for interview questions. Areas addressed include demographic information, cultural practices, history of symptoms, stressors and coping resources, history of therapy, and perspectives on mental

health. Responses to these questions were entered directly into the Interview Guide Form by the researcher during the interview.

Dance/Movement Therapy Sessions

Data from the DMT sessions were collected by three methods.

Participant journal entries.

Following each DMT session, the participant was asked to reflect on her experiences during the session and to write about the reflections in a notebook provided by the researcher. The prompts (Appendix G) included how the participant felt before, during, and after the session, responses to the DMT methods, reflections on the therapy relationship, and any other significant thoughts she may have had about the DMT process. The participant was notified that these journal entries were to be used by the researcher to obtain an understanding of participant experiences during DMT sessions.

Audio-recorded discussion.

The researcher and the participant discussed her written responses. The discussion was audio-recorded for the purpose of transcription.

Researcher field notes.

The researcher recorded field notes about the DMT session (Appendix H, Researcher Observational Field Notes Form). These notes included reflections on the structure of the

session, themes that emerged, movement qualities, meaningful movement phrases and interactions, the therapeutic relationship.

Final Interview

The final interview was guided by a researcher-designed Final Interview Guide (Appendix I). The questions focused on the participant's experience of the DMT process. The researcher also responsively developed questions informed by the in-the-moment interview process. This interview was audio-recorded for the purposes of transcription.

Data Analysis

Audio-recorded interviews and journal entries were transcribed. The data obtained by this research was analyzed using qualitative case study methods, which included the following phases:

Researcher Reflective Procedure

Prior to analyzing the data, the researcher engaged in a second reflexive procedure to further increase validity and reliability in the study. This involved expanding self-awareness to recognize and be able to state the subjectivity and context of the research that had been conducted (Mertens, 2005).

Open Coding

During this phase, the researcher read the transcriptions and deconstructed the data. She employed the method of coding individual words, phrases, and occurrences and

categorized the data until saturation was reached. Each data source was coded individually to identify themes that emerged (Mertens, 2005).

Axial Coding

This step tested the categories established during the open coding, holding them up to the original data source and evaluating their faithfulness to each source. The themes were then analyzed according to context and triangulated to understand the relationships between the themes of each source. The intersections of these codes were used to create overall themes that reflected the data as accurately as possible (Mertens, 2005).

Operational Definitions of Terms, Concepts, and Variables

Asian American

For the purposes of this study, Asian Americans were defined as any person who was currently living in the United States and was either born in or descended from Eastern or Southeastern Asia, including China, Japan, Korea, Vietnam, the Philippines, Singapore, Indonesia, and the Pacific Islands.

Depressive Symptoms

The operational definition of depressive symptoms for purposes of this study was three or more of the following symptoms: feelings of sadness or emptiness; fatigue or noticeable loss of energy; slowed responses or agitation; significant weight gain or loss or change in appetite; difficulty sleeping or sleeping too much; muscle tensions; bodily pain (including but not limited to abdominal distress, headaches, and neck pain); loss of interest or pleasure in

activities they used to enjoy; feelings of worthlessness or guilt; difficulty in thinking, concentrating, making decisions, or remembering; or feelings of hopelessness. This definition included symptoms listed in the DSM IV-TR (American Psychiatric Association, 2000) for major depression and dysthymia with qualifiers removed (for most of the day, frequently). A specific diagnosis of depression was not required for participation in this study. Self-injurious thoughts or plans or suicidal ideation were excluded as depressive symptoms with respect to the outpatient population participating in this study and for purposes of decreasing risk. The criteria "is able to function in usual school, work and/or family roles" was added to remove the severity of symptoms from the realm of major depressive disorder. Symptoms of somatic distress were also added, as these are often symptoms experienced in an Asian expression of depression (Yen, Robins, & Lin, 2000; Waza, Graham, Zyzanski, & Inoue, 1997).

Dance/Movement Therapy

The definition of dance/movement therapy that was used for this study was that of the American Dance Therapy Association (ADTA). Dance/movement therapy is the psychotherapeutic use of movement to promote emotional, cognitive, physical, and social integration of individuals (ADTA, 2009).

Culturally Congruent Therapy

This term was used by the author to indicate an approach to therapy that gives particular attention to working within the various beliefs, values, and practices of a given population. Because culturally congruent therapy is an ideal rather than a quantifiable

outcome, judgments about cultural congruency can only be made by the client along a spectrum from more to less culturally congruent, i.e. more or less in agreement with the client's cultural beliefs, values, and practices. Cultural congruency is affected by the reciprocal communicative conduit between the therapist and client (Sue & Sue, 2008).

Possible Risks and Discomforts to Participants

The overall risks to the participant were estimated to be minimal. There were minimal risks of physical distress from involvement in mild physical activity. However, this risk was no more likely to occur than in daily life or regular exercise and was of a minimal magnitude. The participant may have experienced some self-consciousness and discomfort if she was not accustomed to expressive movement. The participant may have experienced some mild anxiety in experiencing and expressing feelings and discussing health and emotional concerns as part of the study procedure. There was a risk to anonymity and confidentiality in the data colleciton process. All of these risks had a low probability of occurrence because of the steps the researcher took, and they were all of a mild nature and only marginally more significant than risks faced in daily life.

Risks of self-harm are sometimes associated with cases in which depression is severe. The participant in the study was an outpatient, currently engaged in therapy, who had been screened for risk by the director of the center and excluded if these risk factors were present. Participation in the study would not have initiated any risks in this area. However, the researcher would have communicated with the director of the center for provision of support if the researcher became aware of a change in risk status during the study.

Special Precautions to Minimize Risks or Hazards

Precautions were taken to minimize risks the participant may have encountered as a result of participation in this study. Risks of physical distress were reduced by asking the participant if she had any pain or injuries and notifying her not to engage in any movement that was painful or caused discomfort. The participant joined in a physical warm-up to prepare the body for movement. For the duration of the session, her level of physical exertion was entirely up to her and her comfort level. To help alleviate possible stress related to engaging in expressive movement, the reaarcher assured the participant that she was not judged for her dancing ability and that there was no right or wrong way of moving in the DMT session. The researcher also engaged in empathic reflection of the participant's movement so that acceptance was conveyed nonverbally as well. The principle investigator provided consultation for this clinical work to the researcher.

Risks were minimized by recruiting a participant who was already a client at the recruitment location, so she was already aware of anxiety that may arise during the course of therapy and was accustomed to discussing related issues. This insured that addressing these topics was normative for this individual, thereby producing less anxiety than for those who would be new to such an experience. The researcher informed the participant that it was her decision what she chose to share. A physical cool down and discussion at the end of each session was designed to bring closure to the experience of the session and restore the client to a state of equilibrium, mentally and physically, before leaving the session.

The director of the recruitment location was accessible at the center during the study procedure in case a need for support arose. If more than mild psychological distress was

experienced by the participant, she would have been encouraged to speak with the director to discuss these issues.

Risks of self-harm or psychosis are sometimes associated with severe depression. The participant in this study was assessed for risk and would have been excluded if these risk factors were present. Vulnerability was minimized by recruitment from an outpatient setting in which participants were already engaged in and continued in other therapeutic services throughout the study. The study procedure itself did not initiate any risk in this area. However, the researcher would have communicated any concerns she had about a change in participant risk status to the director of the center who could make an assessment, communicate concerns to the participant's primary therapist, and arrange for increased support or referral if needed.

Participant identity was protected through the assignment of a participant identification number (PIN), by which data records were coded for storage. A Participant Contact and Code Form, which listed participant's contact information and PIN, was stored separately from the data records in a secure location and shredded at the conclusion of data collection. Audio recordings were stored without identifying information and deleted upon transcription. De-identified paper data records of researcher field notes and participant journal entries were stored in a locked file cabinet in the Department of Creative Arts Therapies and destroyed three years following conclusion of the study. Transcripts of audiorecorded interviews and journal discussions were stored in CD format in a locked file cabinet in the Department of Creative Arts Therapies and destroyed three years following conclusion of the study. Any publication or presentation that resulted from the study would not include identifying information.

CHAPTER 4: RESULTS

The aim of this qualitative instrumental study was to explore the question of how Asian Americans with depressive symptoms respond to a brief course of dance/movement therapy (DMT), and what form dance/movement therapy (DMT) may take with this population. The therapist/researcher was also interested in whether DMT could serve as a culturally congruent form of therapy for this population, as well as the nature of the cross-cultural relationship between the therapist/researcher and participant. The therapist/researcher contributed to the cross-cultural dynamic as a Caucasian woman who was raised, educated, and trained in the United States. It is also significant that my father and his family immigrated to the United States from Italy when my father was a child. Consequently, I also identify as an Italian American woman and grew up within a bi-cultural environment.

This chapter presents the results by first describing the background of the participant as it was gathered from the initial interview. Next, a narrative description summarizes the structure and content, developing therapy relationship, and therapist/researcher and participant perceptions in the progression of the three DMT sessions. The third subsection reviews the final interview to illustrate the participant's reflection on her experiences. The last subsection explores the six themes that emerged from the five sources of data, including the initial interview, the participant's journal entries, the researcher's field notes, the transcription of each session's discussion, and the transcription of the final interview. The six themes that were found include (a) the development of the therapeutic relationship, (b) the importance of dedicating time to understanding, (c) the support of dance/movement therapy in the expression and acceptance of feelings, (d) valuing and experiencing relaxation and release, (e) the preference for a structured and solution-based therapeutic approach, and (f) Chinese culture and views on mental health.

The data analysis for this process is noteworthy in that there was very little differentiation between the various sources of data. The themes that emerged individually in each data source were the same across all the sources, and no variant themes were present. Because of this, the results that follow do not list discrete themes for each data source.

Summary of Participant's Background and the Initial Interview

The Initial Interview was used to gather demographic data about the participant, as well as her cultural affiliation and practices, history of symptoms, perspectives on mental health, stressors and coping resources, and previous experiences with therapy and movement. This time also served as a means for me to become acquainted with the participant and begin to formulate a fitting structure for their first DMT session.

The participant is a Chinese American female between the ages of fifty and sixty who emigrated from a large city in China with her husband and daughter about twenty years prior to this study. She reported having a good life in this city and that she had never intended to leave, but fear over political turmoil incited her family to move to America. The participant identified as being very Westernized when asked about cultural beliefs and practices that were important to her, describing that the city she grew up in was Americanized and that she had attended an English school. At the same time, she reported the transition of immigrating to America was difficult for her and marked the onset of her depression. She expressed feeling isolated and that she had fewer friends and relatives to support her. She spoke of having left a life of glamour, independence, and professional success in China for being unemployed in America. Her daughter having recently become an adult also seemed to contribute to her feelings of loneliness and isolation.

During this Initial Interview, the participant reported having symptoms of decreased frustration tolerance; fluctuations in weight; a bad temper and feelings of stress; racing thoughts and feeling like her mind was controlling her; distress due to role loss, and feelings of isolation, loneliness, emptiness, depression, and boredom. She described stressors of not having a good job, going through menopause, having few friends, and living in a suburban area where the way of life was slower and their were fewer Chinese people. The participant identified as being a "workaholic". She stated that she doesn't know how to spend time by herself without every moment being productive and that where she was from, everything was very fast-paced.

When asked what she thought about depression and it's causes, the participant responded that Chinese individuals don't usually believe in psychology and counseling or psychiatry and medication. Instead, she stated that being educated and smart, she was expected to change herself and not waste any time. She explained that stressors could be fixed by material solutions, such as studying hard to excel. She mentioned that material success and a good image were important. When discussing the cause of her own depression specifically, she named a conflict of culture and clinging to her past life as causes.

In response to the question of what might be most helpful to work on her depressive symptoms, the participant stated that she wasn't sure and indicated that she thought it was the role of the researcher to determine this. She did state that she was opposed to using medication, but that DMT might be good because it combined meditation and movement and because Chinese people don't want to complain or tell other's their secret or "dirt". She expressed interest in learning how to enjoy the simple life and entertain herself, but that she misses the colorful and successful life that she left in China.

The participants cited people as the primary support for helping her cope with her depressive symptoms and that she isn't happy when she is in the house by herself because she is very social. However, she expressed that this has been problematic for her because she needs to minimize how often she calls her husband. She also listed the television, cleaning, cooking, gardening, and the computer as ways of coping. She stated that reading was not helpful for her and that she prefers active versus passive pursuits.

This participant had experience with psychiatry, counseling, acupuncture, massage, and Cranio Sacral Therapy. She had sampled medication at one point, but never tried it again and believes that it doesn't work for most Chinese people. She sometimes takes herbal supplements because they are natural and have vitamins. She finds her current therapist helpful because she is Chinese, knows the culture and her experiences of being a Chinese American, she speaks Chinese, and doesn't prescribe medication. She expressed an interest in trying art therapy, as well as learning how to calm herself down.

When discussing her culture's reaction to depression, the participant stated that nobody accepts it or talks about it. She expressed pressure to portray the image to others that everything is good, but that there is a tendency to gossip within the family. She asserted that Chinese people want to make everyone happy. The participant also conveyed concern about being blacklisted if others found out about her depression. She decided to seek professional help when she felt like things were getting serious, but stated that her husband didn't want to be bothered with it. She stated that he struggles because he didn't want her to go to therapy, but that he loves her and knew she needed the help.

The participant listed movement experience through tai chi and yoga classes, as well experiences playing volleyball and tennis when she was younger. She asserted that this was

atypical for Chinese people because most don't like physical movement. She shared that she had gone to a prestigious and wealthy school, where grades were very important and participation in athletic activities was minimal.

Dance/Movement Therapy Session Descriptions

The description of the three sessions is derived from researcher post-session field notes, post-session discussion transcription, and participant's journal entries. The narrative describes the movement structure and content, the nature of the therapy interaction and relationship, and the reflections of the therapist/researcher and participant. Each session followed the basic dance/movement therapy structure of warm-up, theme development, and closure. The therapist/researcher entered each session with a tentative structure in mind that she introduced and then often responsively developed during the course of the session.

Session 1 Summary

The first DMT session began following the Initial Interview. As indicated in the researcher observation notes, I initiated some breathing exercises for the warm-up, and then guided the participant through movement that moved sequentially through the body using different movement qualities, or what are referred to as Efforts in Laban Movement Analysis. The Efforts involve a Strong or Light attitude toward Weight; Direct or Indirect attitude toward Space, Sudden or Sustained attitude toward Time, and finally Bound or Free attitude toward Flow (North, 1972). Based on both the researcher observation notes and the participant's journal, the Effort qualities Direct and Indirect seemed to resonate with the participant based on movement tasks in which I guided the participant. We called a phrase that emerged the

"Focused Walk," which involved moving with Direct and somewhat Sudden movement qualities straight toward a specific selected point in the room. I then asked the participant to explore the opposite in movement. The result was the "Meandering Walk," which used Indirect and Sustained movement in the course of exploring the room and taking in all the details while traveling a wandering path. I created this movement structure of two disparate ways of moving across the room to reflect the participant's description in the initial interview of her experience of transitioning from a fast-paced way of life in China to a slower, more simple lifestyle in America. I noted in my field notes that this seemed to be a salient theme for the participant during this session, as was stress caused by migration and acculturation and difficulty just sitting or being.

The researcher field notes indicate that the participant's behavior during the session was characterized by a lot of verbalization and very specific mirroring of my movement. I observed that the participant had difficulty initiating her own movement and instead verbalized her responses to my prompts. When given examples of possible ways to use movement to express feelings, the participant followed my movements with meticulous care. I indicated that she did seem to have a preference for quick, direct, and bound movement. I also wrote in the field notes that when checking in with her to gauge her response to a given intervention or type of movement, the participant consistently said that everything was fine.

In the post-session journaling, the participant relayed that she had felt calm prior to the session, fruitful during it, and relaxed afterwards. She expressed that the "Focused Walk" helped divert her mind from her troubles and the "Meandering Walk" helped her see things that she hadn't observed before. In response to the discussion question of what movement activity was helpful, she stated that all of the movement was good, but that she wished the session was longer.

A similar view was expressed when asked about the helpfulness of the researcher. The participant stated in the discussion that the researcher was polite and accommodating, but that more time was needed since there is a lot of difference in their cultures to explain and understand the differences. However, the also reported in both her journal and the discussion that the session was respectful of her cultural values and beliefs about healthcare, stating that it helped her release anger and other feelings as it is difficult for Chinese people to express or expose these feelings to others and that it didn't involve medication.

Session 2 Summary

As described in the researcher field notes, the therapist/researcher began this session with a warm-up that focused on moving back and forth between Bound Flow and Free Flow, using tense and release exercises. Based on my interaction with the participant, I developed this warm-up into a movement phrase that combined four of these exercises into a sequence. Three of these movements utilized an exercise ball or the wall as supports. Tensing and releasing were key components to the sequence, as was Passive Weight, which involved letting certain body parts hang without resistance. The key body parts stretched in this sequence included the chest, back, legs, ankles, and shoulders.

My notes reflect that the conversation during this session related directly to the movement. The participant reported feeling as though she was able to release her tension and feelings through these exercises. We discussed activities that might provide a catalyst for expression, including singing, writing, drawing, and movement. I recorded that the participant was very responsive to suggestions for exercises and other advice and that she expressed enthusiasm to try these ideas at home. I indicated that my sensation was that the participant felt

joined and understood during the session and I felt a therapeutic relationship beginning to develop. The participant also seemed more comfortable initiating with me and giving feedback about the session.

In both the post-session journaling and discussion, the participant reported feeling tired and stressed prior to the session, started to relax during it, and said she was relaxed and calm afterwards. She stated that all the movements were helpful, and mentioned using the exercise ball and the shoulder tension and release in particular. The participant expressed that talking with the researcher about her loneliness and being upset was helpful, stating that the researcher was observant and understanding and helped by suggesting solutions like movement, singing, writing, and drawing. She stated again that the DMT was respectful of her cultural beliefs and that it helped her to release her anger and depression, something which she didn't have anyone to talk to about.

Session 3 Summary

The therapist/researcher began this session by using the routine from the second session as the warm-up. Next, I introduced a meditation exercise. To close the session, I repeated the routine and integrated the "Meandering Walk with the experience of meditation. I focused this session on noticing emotions without having to act on them, which was a response to the participant's question of what she could do when she couldn't use one of the activities discussed during the second session to express her feelings. This session delved into more uncomfortable feelings and how to cope with them, but I indicated in the researcher field notes that the participant seemed like she was trusting of me and the DMT process.

In the post-session journaling, the participant expressed feeling okay before the session, started to relax during the session, and was calm afterwards. She found that the release movement with the exercise ball helped her totally relax her body. The participant reported that the walking exercise helped her let go of her fear. She found the researcher to be understanding and stated that the researcher new exactly what could help her. The participant wrote that she found the DMT to be respectful of her culture because it could help in facing her fear but also letting it go since she says that Chinese individuals don't like to speak up about or express their feelings. She then reiterated this sentiment in the discussion.

Final Interview Summary

The Final Interview checked in with the participant by phone after all the DMT sessions had been completed. It inquired about the current state of the participant's symptoms, if the DMT was helpful related to these symptoms, what she may have found helpful or not, whether or not she found it to be supportive within her cultural beliefs about healthcare, her overall response to the DMT, and if she would recommend it to a friend of Asian American descent who had depressive symptoms. She was also given the opportunity to comment on any other thoughts she had as it pertained to the DMT sessions, her journal entries, the post-session discussions, or otherwise.

The participant reported loneliness and difficulty coping with life stressors as the two symptoms she was currently experiencing. She expressed that her loneliness sometimes causes her to be unhappy, a feeling she wants to do something to avoid, but that it's better if she doesn't do anything. She described a change in how she copes with her loneliness, saying that instead of trying to avoid it by calling her husband while she's driving or spending money, she tries to just

let it be and says that everything still ends up being okay. She reported that the DMT had helped her with these symptoms, and though she hasn't been doing the exercises from the sessions, she has been swimming and states she feels better when she has exercised. The participant said she would like to practice the suggestions that we had discussed, but that she didn't take it too seriously in between sessions because she wasn't given specific tasks to complete at home. She did report enjoying the movements during the sessions and that she had liked the DMT and wanted to come back for each subsequent session.

The participant was doubtful that Chinese friends would tell her if they were depressed, stating that most Chinese people aren't as open or talkative as she is, particularly when they have a problem. Yet, she said that if a friend did confide in her about being depressed, she would tell them about DMT because she found it to be very useful for her. The participant expressed that she had no expectations going into the study, but found that she really like the DMT sessions. The remainder of the interview consisted of suggestions from the participant about ways the sessions could be improved, which included primarily needing additional time and sessions and providing more structured tasks and guidance for the client to utilize some of the DMT techniques at home.

Table 1

Group Themes and Data Source Examplars

Group Themes	Initial Interview	Researcher Field Notes	Participant Journal Entries	Discussion	Final Interview
Development of the therapeutic relationship	Current therapy helpful because she likes the therapist and therapist knows and understands her culture and speaks the language	Evolved from participant as passive and aggreeable in the first session to researcher feeling connection in the second session and finally developing trust and rapport to delve into less comfortable feelings in the final session (Sessions 1-3)	Evolved from therapist as polite and accommodating after first session to helpful, understanding, and very observant after the second session, to very understanding and knowing exactly how to help after the third session (Sessions 1-3)	Evolved from understanding and respectful of privacy in first session, to observant and good to talk to, in second session to, "I am actually surprised because you are very young. Bbut you are very understanding and you know exactly what's going on. So I can see that you are a very good therapist… I never judge people before, but you do, you see, like beyond my expectations," in the third session (Sessions 1-3)	"Actually I think you are a wonderful person and so very mature…. You have very good ideas and I think that they were really helpful… Thank you so much, okay? And you teach me a lot of things and I really, really appreciate it."

Group Themes	Initial Interview	Researcher Field Notes	Participant Journal Entries	Discussion	Final Interview
Importance of dedicating time to understanding	Participant tried quick-fixes previously, has more time for therapy now	N/A	"All [movements] are good and I wish it's longer as we just started… There's a lot of difference in culture so [we] need time to explain and understand." (Session 1)	"I do feel you can understand me; we had no problem in communication. But you see, it's a totally different culture and history and background. So you definitely need a longer time before everything can be understood." " I do feel that, you see, the actual dance/movement session should be a little bit longer because each of the steps, we can only do it one time or two times before I really understand what to do. Then what's the function and benefit of it, it's done." (Session 1)	"It would be better if they have more sessions, if it's going to happen... It's not many things, you see, can be accomplished. More time, I think it would be better."

Group Themes	Initial Interview	Researcher Field Notes	Participant Journal Entries	Discussion	Final Interview
DMT as a support in expressing and accepting feelings	DMT as good because it combines meditation and movement and because Chinese individuals don't want to complain or tell others their secrets.	Difficulty with feelings when just sitting or being, meaningful movement developed in Focused and Meandering Walks (Session 1). Creation of a tension and release routine utilizing bound and free flow, as well as discussion of using song, movement, and writing to release feelings (Session 2). Continuation of the tense/release phrase and the Meandering Walk as meditation. Releasing emotions and noticing them without acting on them (Session 3).	Arriving at a state of calm and relaxation at the end of the DMT. Movement phrases as diverting her attention, observing new things, relaxing the body, and letting go of fear (Sessions 1-3)	DMT as easier than yoga, helps her calm down because of "releasing the frustrations and…relaxing the muscles" (Session 2). "I think it's useful, especially this time you talked about that I should face my loneliness and fear and all that by taking small steps, by walking leisurely and thinking of all the anxiety or loneliness, and then just let it go" (Session 3).	Recommendation to ombine DMT with verbal therapy and using it to assist in expressing feelings

Group Themes	Initial Interview	Researcher Field Notes	Participant Journal Entries	Discussion	Final Interview
Valuing and experiencing relaxation and release	Learning how to calm herself down and to enjoy the simple life	Wanting help calming down (Session 1); emerging theme of tension and release, both physically and emotionally (Session 2); emerging theme of meditation (Session 3)	Reported the process of DMT helped her to become relaxed and calm (Sessions 1-3). "The ball helped me to relax my body totally" (Session 3)	"I really like it because, you see, it helped me to relax myself. So, I'm also tense, usually I'm very easily tensed up. Like the big ball that I lean on, I feel that that ball can support me so I can really relax. I'm like floating on it so I feel like I'm freeing myself. Some other movements are good to, because like my shoulders are so tense. When I put them up and then drop them, then I realize that my shoulders are so stiff." (Session 2)	N/A

Group Themes	Initial Interview	Researcher Field Notes	Participant Journal Entries	Discussion	Final Interview
Preference for a structured and solution-based therapeutic approach	Turning the question of what would be helpful back to the researcher, listing specific activities as ways of coping	Difficulty initiating own movement (Session 1), specific advice and exercises resonate, enthusiasm to try at home, responsive to suggestions (Session 2), concern about what to do when she can't use the suggestions to express feelings (Session 3)	Listed specific solutions and exercises as helpful- focus walk and walk around tour (Session 1), singing, writing, and drawing (Session 2), meditation and walking to face feelings and let them go (Session 3)	" I always say that I feel lonely and by myself, and you have some suggestions, like singing, or moving, or writing, which would be good so then I can do something instead of just sitting there still keep on thinking." "I think you do good. And because to tell you the truth, I have no idea what you're doing, and I don't want to tell you what I need to be done because I have no idea." (Session 2)	"Yes, so people can practice, you understand what I'm saying. And besides, if you don't tell them, actually, I actually forget. And so, even up to today, I did not buy the ball. But if I, you see because you did not tell me exactly tell me where it is, and I'm lazy, and then when the depression happens, or the loneliness happens, that will be too late at that moment to get it… and then each time, you see, you can emphasize that I hope you can try to do this type of exercise everyday, you see, how many times and then especially when loneliness or depression happens again I would really like you to try and then next time tell me what happens."

Group Themes	Initial Interview	Researcher Field Notes	Participant Journal Entries	Discussion	Final Interview
Chinese culture and views on mental health	Chinese people aren't accepting of depression, don't talk about mental health, but the family gossips amongst itself, you can be blacklisted. Chinese people want to make everybody happy and show that everything is good.	Migration and acculturation stress	DMT is respectful because it helps to release anger since Chinese don't like to express of expose to others, doesn't use medication (Session 1) It is helpful in releasing the anger and depression that she doesn't have anyone to talk to about (Session 2) "We Orientals don't like to speak up or express. This can help us face the fear and let it go." (Session 3)	"I think it's good because, you see, Chinese they are afraid because of what people will stigma on them or because we hate medication, so once you step on any of those issues, we don't even try. You may be very successful, but we don't even come, so that's the thing. But, when you mention the name is only dance/movements, it's not a stigma of that I'm saying I'm depressed or whatever, so the whole thing is easier to approach. Once you approach, and then we find out that it works." (Session 1)	"Yes, I definitely, you see, think that it's very useful. Unfortunately, I don't think anyone, because most Chinese are not as open as me, most Chinese would not, you see tell me that they are depressed. So they don't talk so much. But if they do tell me and I definitely would tell them… Because as you know, the Orientals are more, you see, not so outspoken about their problems, especially if you have a problem, with their friends."

Emergent Themes

Development of the Therapeutic Relationship

The first theme that materialized from the data was the development of the therapeutic relationship. Evidence of this transition was visible in each of the five forms of data. During the Initial Interview, the participant described the therapeutic rapport between her and her current therapist as the primary element of what was helpful about her therapy. The researcher's field notes tracked the development of the relationship between the researcher and the participant through each session. I recorded that during the first DMT session, our relationship was characterized by the participant closely following all of my movements. She was open and talkative with me verbally. However, each time I checked in with her to gauge her response to a particular DMT structure or technique, she would reply that everything was "fine" or "okay" and gave me little feedback otherwise. In her journal entry for the first session, the participant noted that I was polite and tried to be accommodating. During the discussion, she elaborated on this and stated that I was "very understanding". She also stated, "You respect my privacy, which of course is the most important for me."

The therapeutic relationship seemed to blossom during the second DMT session. The researcher field notes observed that the participant appeared to feel understood and met by my actions and that she was more comfortable with initiating and giving feedback during the session. I also noted that I had felt a therapeutic connection during this session. The participant wrote in her journal that I was "very observant and understanding and gave good suggestions". She also stated that it was helpful when we talked about her loneliness and

being upset, which indicated that she was comfortable in discussing her feelings with me. She reiterated this during the discussion, saying, "But more important, I like when you talk with me."

The third and final DMT session tested this relationship. I noted in the researcher field notes that the rapport seemed good between the participant and I, and that she was still trusting of me even when we moved towards less comfortable feelings, such as using meditation to sit with her feelings of anger or loneliness instead of acting on them. The participant's journal response seemed to support this trust in me, as demonstrated by her comment that I am "very understand and she knows exactly what can help me." The participant corroborated the strength of the therapeutic relationship again during the discussion, where she expressed having been surprised at how good of a therapist she thought I was considering my age. She expressed that I had gone "beyond her expectations" and knew "exactly what's going on."

The data from the Final Interview upheld my postulation that the participant and I were able to develop a sound, though brief, therapeutic relationship during the study. She mentioned that I was wonderful on four separate occasions during this interview, and stated that she would "love to help" if I needed anything else. She indicated that she was appreciative of the ideas and options I had provided and that they taught her and were helpful to her. It is possible that the participant's positive regard for me and our relationship could be exaggerated because of the Chinese value of being respectful and pious towards authority figures. However, it would seem that the evolution of our relationship and her increased openness toward and trust of me indicates that there is at least some reality to the participant's statements.

The Importance of Dedicating Time to Understanding

Needing additional time was a theme that came up repeatedly, but especially during the first DMT session and the Final Interview. This theme was first mentioned briefly in the Initial Interview, when the participant was discussing her previous experiences with therapy. She mentioned that she had tried some quick-fixes before, but that she had more time now to dedicate to the issue. In her journal entry from the first session, the participant expressed wanting or needing more time on three separate occasions. She indicated that she found the movement helpful, but that she wished it had been longer so that she could really use and understand the interventions more. She also expressed that the differences between my culture and hers created a need for more time so that we would have the opportunity to explain and understand the cultural differences. She explains this further during the Discussion from Session 1, stating, "If I want to explain to you what happened to certain of our cultures, I need to explain to you, otherwise you won't understand. So you take time."

In addition to needing to take time to familiarize me with her culture, the participant also indicated during the Discussion that she needed more time doing each of the DMT tasks. She explained that it took her several repetitions of a given movement before she felt like she understood it, and then the session was over before she could derive the full benefit of the movement experience. The participant emphasized this again during the Final Interview, saying that both more sessions and more time would be beneficial so that she could be introduced to additional DMT tasks and experiences. She also mentioned that this would be helpful since depression and loneliness are not something an individual can conquer in just a

few sessions. Although it wasn't specifically mentioned in the researcher's field notes, the brief nature of this intervention has been indicated as a limitation of this study.

Dance/Movement Therapy as a Support in Expressing and Accepting Feelings

The participant reported that she found DMT to be a medium through which she could express and release emotions that she otherwise felt like she had to conceal. In the journal entries from all three sessions, the participant reported that the DMT sessions had helped her relax and become calm. She began the study with a positive attitude towards DMT, as indicated by her naming DMT as a modality that would be helpful in working on her depressive symptoms during the Initial Interview. She offered this because it combined aspects of meditation with movement, which diminishes some of the pressure to express things verbally. According to the participant, this is good because Chinese individuals don't like to complain or tell other people their secrets.

Both the participant and I listed particular movements that became meaningful over the course of the DMT sessions. In the researcher's notes for Session 1, I marked that the participant expressed difficulty with just sitting or being, and that she was interested in finding ways that would help her calm down. The meaningful movement that emerged from this session was two distinct types of walking. The first, which we called the Focused Walk, involved moving directly towards a particular target. The second walk, or the Meandering Walk, was characterized by a leisurely pace and taking in all of the elements of the room while wandering without a particular pattern. In her journal entry from Session 1, the participant stated that the Focused Walk helped her divert her mind from her troubles, while the Meandering Walk helped her take notice of things she hadn't observed before. During

the Discussion, she expressed that the DMT was even better than she had expected because her previous experience with meditation was that she couldn't focus. However, with the DMT, she was able to divert her focus onto the movements instead of what was on her mind, including her worries and her depression.

The researcher field notes from the second DMT session mention the creation of a movement phrase involving tensing and then releasing various parts of the body. This routine incorporated the use of the Bound Flow Effort and the Free Flow Effort, which is associated with the expression of feelings in Laban Movement Analysis. The notes from Session 2 also identified the discussion of releasing feelings through writing, singing, and moving in connection with this movement phrase. The participant's journal entry highlighted stretching with the exercise ball and the shoulder drop, two components of the aforementioned movement phrase, as movements that were particularly helpful. During the Discussion of this session, the participant again compared the DMT to yoga and meditation, but stated that the DMT was helpful and easier to do, whereas during the yoga meditation, she had difficulty calming down when she was upset or lonely, and this sometimes made it worse. She elaborated that moving and relaxing the muscles helped her release her frustrations, which helped distract her from dwelling on what was making her upset. Furthermore, she found the exercise ball to be supportive in helping her relax and compared it to floating, as though she were freeing herself.

During the third session, I indicated in my field notes that the tense/release movement phrase persisted as a meaningful movement experience. This came together with the Meandering Walk, which became a representation of meditation while moving. This session also focused on the theme of noticing emotions and accepting them, but not acting on them.

The participant paralleled this evaluation by indicating that the exercise helped her relax her body totally and that the Meandering Walk helped her to let go of her fear.

During the Final Interview, the participant mentioned that the DMT experiences could be combined with verbal counseling, with accommodations and modifications for each individual, to help ease an individual into expressing their feelings in the context of the therapeutic relationship.

Valuing and Experiencing Relaxation and Release

Starting in the initial interview, the participant expressed a desire to be taught how to calm herself down. She was also interested in learning how to enjoy the simple life. This theme of release, relaxation, and calm came up throughout the DMT process, particularly in combination with the theme of DMT as a support in expressing and accepting feelings. While it seems connected to this theme, it came up frequently enough that it stood out as an additional, independent theme. Even though these themes are being differentiated, it's unclear at times if and how the participant distinguishes expressing feelings from the physical release of tension from holding in feelings.

I noted in the researcher field notes from the first session that the participant was interested in getting help with calming down. This request became a guiding force in creating the structure of the sessions. In a way, I considered it to be her presenting problem. In turn, I introduced the theme of tension and release in the second session and the practice of meditation in the third session. In her journal entries from all three sessions, the participant responded to the prompt of how she felt during and after the DMT sessions by saying she became calm and relaxed.

One particular exercise seemed to resonate most with the participant regarding this theme. The participant mentioned the use of the exercise ball as a support to stretch the back and chest in her journal entries, the post-session discussions, and the final interview. Of all the interventions, she referred to this one most often when talking about the usefulness of DMT.

During the post-session discussion for the second session, the participant mentioned that she had tried yoga previously, but that it didn't help her calm down because she couldn't let go of her feelings of loneliness and being upset. However, she stated that DMT helped her calm down because she could release the frustrations and relax her muscles. The participant also referenced the Meandering Walk as a way of facing her loneliness and fear, but then just letting it go in the third post-session discussion. The participant mentioned the exercise ball during the final interview, which I associate with our relaxation routine, but she did not specifically refer to relaxation or release.

The Preference for a Structured and Solution-Based Therapeutic Approach

A preference for a structured and solution-oriented therapy was a prominent theme during the course of this study. This theme was pervasive starting with the Initial Interview. The participant stated that she wanted to be taught how to calm down and to learn how to enjoy the simple life and entertain herself. When asked about what might be helpful for her depressive symptoms, she said she wasn't sure and turned the question back to me. She then stated that people are her supports for coping with her depression, but felt that she needed to change this reliance on others and listed television, cleaning, cooking, the computer, and

gardening as other coping skills she uses. She also mentioned that she prefers active hobbies to passive ones.

During the first session, the researcher's field notes indicated that the participant had some difficulty initiating her own movement and instead followed my lead quite closely. Though I had offered her the option of improvising her own movement, the participant did not choose this option. Her journal entry names the specific task of the Focused Walk and the Meandering Walk as movements that were helpful to her. Based on this response, I continued to make specific suggestions, give advice, and use structured exercises in the second session. The field notes from this session indicate this approach seemed to resonate with the participant and that she was enthusiastic about trying some of these things, such as writing, drawing, singing, and moving to release feelings, at home. Indeed, the participant's journal entry also indicated that she found these suggestions to be a helpful part of the session and she reiterated this during the discussion.

The field notes from the third session highlight that the participant was concerned about what to do when she was unable to express her feelings through dance or singing. We began to discuss meditation as an option for when the other suggestions were not feasible. The participant relayed in her journal that she found the meditation with walking to be a good way to face her feelings and then be able to let them go. During our Discussion, the participant clarified further: " I think that it's useful, especially this time you talked about that I should face my loneliness and fear and all that by taking small steps. By walking leisurely and think of all the anxiety or loneliness and then just let it go. And then, eventually, maybe start with some small meditations, and so I can feel how instead of

avoiding them… so I can find out that actually it's no big deal. So you see, and then I can overcome it. And I really like it."

During the final interview, the participant reported that she had thought especially about the method of just letting feelings be instead of avoiding them and that she had tried this and found that everything was still okay. At five distinct moments, the participant offered the suggestion that it would be helpful to have specific tasks to do in between each session. She recommended that it would be helpful to receive information about where to buy the exercise ball, to have pictures to remind her about the various movements we did, and then be assigned a certain number of repetitions to complete each day for practice.

Chinese Culture and Views on Mental Health

The final theme that came up consistently was the role of the participant's Chinese culture in her values and beliefs about mental health, as well as in her experience of her depressive symptoms. It emerged most often in relation to the idea of expressing feelings, a concept that the participant asserted was not common in her culture. The topic of culture first came up during the Initial Interview as one of the stressors that the participant cited as causing her depression. She expressed that a conflict of culture and clinging to her past life was a contributing factor to her depression, and indicated having difficulty with acculturation and migration stress, even though the city she had migrated from was very Westernized. In this way, she simultaneously sought to educate me in the ways of the Chinese culture and about their values, but also differentiated herself as different from most Chinese people, in that she was more Westernized. The researcher field notes also mentioned this as a salient theme from the first session. The participant remarked during the Initial Interview that the

Chinese don't usually believe in psychology, counseling, psychiatry, or using medication. Furthermore, she added that in her experience, people of Chinese descent aren't accepting of depression and it isn't something that is acceptable to talk about. In fact, she commented that people can be blacklisted for having mental health issues. The participant also mentioned that Chinese people want to make everybody happy and put forth the image that everything is well, which contributes to the hesitancy to talk about mental health issues. Even though this stigma exists, the participant expressed that having a Chinese therapist who speaks the language and understands her culture and the experiences she's been through was helpful for her.

The participant expressed that the DMT sessions were helpful for her in releasing her feelings, particularly in light of not wanting to expose these issues to others and not having anyone to talk to about them (Journal Entries 1-3). She also found that this was useful for her in letting go of these feelings. This sentiment was mirrored in each of the Discussions. In the first Discussion, she mentioned that DMT may be easier for Chinese individuals to approach and try since the dance/movement aspect doesn't have the stigma of saying that you are depressed, and that once they have tried it, they will find that it works. The participant again affirmed that the DMT would be helpful for Chinese individuals during the second discussion, stating that the movements can help them release the anger they hold internally since they don't like to express themselves. She reiterated this in the third Discussion, saying that DMT could be really useful for any culture as a method for beginning to facing feelings and conquering them. She said this was especially true for Chinese individuals, offering that "instead of like storing all the things inside and not telling anyone, then they can use actions or singing or you say like painting or do anything, or just face them, to, you see, let them go."

During the Final Interview, the participant was asked about whether or not she would recommend DMT to someone from her culture who was also experiencing depressive symptoms. She agreed that she definitely would because she found it to be very useful, but that she didn't think it was likely that her Chinese friends would confide in her if they had this problem since they are not as outspoken about their problems. It is because of this tendency of the Chinese to be reserved about expressing feelings that the participant thought that DMT could be helpful as an alternate way of expressing themselves.

CHAPTER 5: DISCUSSION

This study asked how Asian Americans with depressive symptoms responded to a brief course of dance/movement therapy (DMT) and what form the DMT sessions may take with this population. Six themes emerged and are outlined in Table 1, including the development of the therapeutic relationship, the importance of dedicating time to understanding, DMT as a support in expressing and accepting feelings, valuing and experiencing relaxation and release, the preference for a structured and solution-based therapeutic approach, and Chinese culture and views on mental health. Each of these themes can be related to theoretically- or research-based literature included in the literature review. This chapter will first present these six themes in the context of the literature. It will then explore some of the implications for practice the resulted from the study. Next, the strengths and limitations of the study will be described and suggestions will be made for future research in this topic area. Finally, I will offer my reflections on the study as the researcher and therapist.

Results in Context of the Literature

The theme of the development of rapport between a therapist and client is fundamental to therapy. This is particularly relevant in therapy that involves cross-cultural relationships, as cultural sensitivity can be difficult to develop and there is a greater risk of misunderstanding. Acknowledging and addressing differences between therapist and client may provide a foundation that works towards developing trust (Sue & Sue, 2008; McGoldrick et al, 2005). The participant in this study initiated this herself in her journal entry and the discussion from the first session, mentioning that there was a lot of difference

between our cultures and that it was important for her to explain her history and background so that I would understand. The DMT process also supports this by employing the technique of meeting the client where they are and structuring the session in response to his or her needs and preferences so that they may feel understood and accepted (Chaiklin & Schmais, 1979).

Taking time for the therapist to get to know the culture of a client was a salient issue for the participant. She mentioned throughout the process that it was important for me to understand her background and culture. Many authors have touched on the value of learning about the worldviews of their clients in order to provide culturally competent care (Sue, Arredondo, & McDavis, 1992; Sue & Sue, 2008; Hanna, 1990; Dosamantes-Beaudry, 1997b; McGoldrick, Giordano, & Garcia-Preto, 2005). Sue and Sue (2008) mention the specific need to align the modalities and goals of the therapy with the values and experiences of the client. To accomplish this, the therapist must take the time to have the client inform them about as much of their cultural background as they choose.

One of the Asian American values that came up frequently for the participant was not expressing or exposing feelings to others and not having anyone to talk to about them. Sue and Sue (2008) discuss that emotionality in an individual can be viewed as immature and lacking in restraint. They suggest an indirect approach to discussing feelings, which the participant corroborated as being helpful. The participant asserted that using movement as a way to express feelings is supportive since Chinese Americans don't like to talk about them. She also commented on multiple occasions that the DMT provided her with an opportunity to express and release feelings that she otherwise had to conceal, which developed into the theme of DMT as a support in expressing and accepting feelings. Levy (1988) asserts that

altering the pattern of an individual's movement behavior can influence his or her emotional state and can improve his or her welfare. This was reflected in the introduction of movement phrases like the Meandering Walk and the tense and release routine that was created during the DMT sessions.

The participant also indicated that these movements were helpful to her in experiencing a state of calm and relaxation, observing new things while diverting her attention from her depression, and releasing her fear. Furthermore, the tense and release routine employed the Efforts of Bound and Free Flow, which correlate with the control or freedom of the expression of feelings (North, 1972). Therefore, the relaxation and release that the participant described in her experiences of the DMT sessions may have provided another outlet for expressing feelings that are otherwise concealed. This may also relate to Sue and Sue's (2008) assertion that Asian Americans have a tendency to report emotional stress through somatic problems, which could contribute to the conflation of the DMT as a support in expressing and accepting feelings and valuing and experiencing relaxation and release themes.

In both her verbal and movement responses, the participant expressed a preference for a structured and solution-based approach to the therapeutic process. She named particular exercises as being helpful and was receptive to suggestions, was not as responsive to improvisational movement, and requested tasks to complete at home with a catalogue of pictures to help her remember them. She also stated, "I think you do good. And because to tell you the truth, I have no idea what you're doing, and I don't want to tell you what I need to be done because I have no idea," (Discussion, Session 2). While she did increase the amount of feedback she gave me over the course of the three sessions, she also seemed to

regard me as an authority from whom she should take specific direction. This is demonstrated by her comment in the initial interview that she wasn't sure what would be most helpful to work on her depressive symptoms, and she wanted my perspective on it. In movement, this was exhibited by her meticulous reflection of my movement. The literature cites that Asian Americans tend to value traits such as obedience and filial piety, which could contribute to a preference for a specific structure to follow (Sue & Sue, 2008; Lee & Mock, 2005). Focusing on the presenting problem and using specific, solution-based goals, and a problem-solving technique is recommended as a means of demonstrating support of Asian American cultural values. It is also noted that the therapist may need to be more directive and provide more structure for this population, but that the therapist can generate choices for the client and empower him or her to be part of the process of developing his or her goals and making the choices (Sue & Sue, 2008; Lee & Mock, 2005).

The differences between traditional Asian values and American values, as well as difficulty adjusting to America, the change in pace and occupational role can all create acculturation and migration stress (Lee & Mock, 2005). The participant named these issues in describing the cause of her depression. Consequently, the cross-cultural nature of our therapeutic relationship may have had potential benefits in addressing her acculturation stress and the stigma of mental health and feelings. As a Westerner, I could have represented a bridge to explore the intersection of the two cultures she was straddling. The opportunity to explain her culture to me may have provided a canvas to promote growth, understanding, and integration for her.

Cultural beliefs about mental illness can also greatly affect the likelihood that an individual or population will seek treatment, comply with treatment, or may be deterred by a

clinician's approach to treatment. Consequently, it is critical for clinicians to be aware of and accommodate these beliefs in order to reach the Asian American population and give them effective care (Gonzalez, Tarraf, West, Chan, Miranda, and Leong, 2010; Givens, Houston, Van Voorhees, Ford, & Cooper, 2007; Wong, Kim, and Tran, 2010; Fogel and Ford, 2005). The role of stigma in discussing mental health and seeking services was present in the participant's references to problems and therapy. She discussed the stigma of not being able to talk about mental health without being ostracized during the initial interview. She also acknowledged during the first discussion that the possibility of being stigmatized for seeking treatment or taking medication is very influential in whether Chinese Americans decide to seek services. Approachability of services is important, particularly regarding the image the services may portray to others. Because DMT emphasizes dance and movement in its title, the participant found it to be easier to approach. While she found it to be useful and would recommend it to others, she indicated that she didn't think her Chinese American friends would be outspoken about their problems or open enough to confide in her about them.

Implications for Practice

America has long been known for being a place where many different ethnicities and cultures interface. This results in a plurality of perspectives, values, and beliefs to take into consideration when working with clients. A therapist must be attuned to his or her own assumptions of the nature of the world, as well as to those assumptions of his or her client, with the knowledge that these assumptions will influence both diagnosis and the course of treatment (Hanna, 1990; Sue, Arredondo & McDavis, 1992; Dosamantes-Beaudry, 1997b; McGoldrick, Giordano & Garcia-Preto, 2005; Sue & Sue, 2008). Significant differences in

matters concerning diagnosis, symptomatology, help-seeking, and treatment have been supported by the research for Asian Americans as compared to the American standard, which again emphasizes the need for the therapist to have awareness of his or her own cultural values and biases, as well as those of the clients they treat (Nakao & Yano, 2006; Yen, Robins & Lin, 2000; Waza, Graham, Zyzanski & Inoue, 1999; Kim & Chung, 1993; Lehti, Johansson, Bengs, Danielsson & Hammartröm, 2010). Moreover, clinicians must be careful not to categorize all Asian clients together in their efforts to be culturally aware, but to consider the individual nationalities, histories, and cultures of a given client and the corresponding effects those elements may have on mental health issues.

In exploring the cultural differences of Asian Americans and their impact on therapy, dance/movement therapy surfaces as a possibility for a culturally appropriate modality for the treatment of depression in Asian Americans. The participant indicated that the use of movement to express feelings served as a support because of its use of the body to release these feelings without necessarily having to verbalize them. Because of the burden of stigma that surrounds mental health issues in Asian American culture, it is important that clinicians are sensitive to privacy and confidentiality when working with this population (Lee & Mock, 2005; Yen, Robins, & Lin, 2000; Fogel & Ford, 2005).

Particular attention should be given to developing rapport and trust in the therapeutic relationship, especially in cross-cultural relationships. Giving the client the opportunity to explain his or her history, background, and cultural values may be beneficial in developing this relationship (Sue, Arredondo, & McDavis, 1992; Sue & Sue, 2008; Hanna, 1990; Dosamantes-Beaudry, 1997b; McGoldrick, Giordano, & Garcia-Preto, 2005). It is critical that the clinician take care in making interpretations about client behavior without asking the

client about that behavior and having knowledge about the cultural traditions that may influence this behavior. For example, it would be easy to misunderstand the obedient nature, passivity, or hesitancy about improvisation without knowing about the influence of values such as filial piety, respect for authority, and passivity in the role of student in Asian American culture. This implication is demonstrated in the participant's desire for having enough time to explain her culture and her background to the therapist/researcher.

Working as a therapist necessitates an appreciation for diversity and the ability to see clients as individuals. This requires an understanding of the specific considerations for work with particular groups, be they ethnic, gender, socio-economic, or any other method of classification we may use to help inform our work. While client individuality remains the key focus of therapy, the client's cultural influences and beliefs are a critical source of information for providing appropriate, effective, and empathetic care. Sue and Sue (2008) developed a tripartite model for identity, which acknowledges an individual level, group level, and universal level of identity. The participant frequently referred to the importance of support from family and friends, avoiding stigma and presenting an acceptable image for the family, and confidentiality. Because of a tendency towards a collectivist orientation, it is critical that a therapist not exclude the group level of identity when working with Asian American clients.

It could be useful to begin DMT with an Asian American client with a more structured and solution-based approach (Sue & Sue, 2008; Lee & Mock, 2005; Dosamantes-Beaudry, 1999; & Chang, 2006). Specific tasks and exercises may be used at first, with a gradual transition to more improvisational movement if it seems appropriate. Based on the suggestion of the participant, giving assignments to be worked on in between sessions may

also be helpful in providing structure and helping to integrate the experiences of each session. Because the need for time also emerged as a theme, it could also be beneficial to inquire about the pace of the sessions and to offer sufficient time to the client to discuss cultural issues.

Strengths and Limitations of the Study

This study documented the course and experience of a Chinese American participant engaged in dance/movement therapy over three DMT sessions and her reflections following the course of therapy. The qualitative nature of the study allowed for a rich narrative to be obtained about the participant's thoughts, feelings, and reactions to DMT that may provide some insight for clinical work with this population and a better sense of some of the possibilities

There are several limitations to this study. The researcher played a dual role and also acted as the therapist during the study. The participant was selected for convenience factors and only one participant responded to recruitment and enrolled in the study. As a qualitative case study with only one participant, the results are not generalizable to a larger population nor are they able to comment on differences between nationalities. Both the Caucasian co-investigator, as well as the Chinese American participant, may encounter cultural misunderstanding or misinterpretation. Another limitation is that the self-report data, including the interviews and journals, are subject to the participant's abilities to self reflect and accurately describe her experiences. The positive responses may also be exaggerated by the client due to the cultural value of being respectful and agreeable to authority and wanting to appease others. Furthermore, the brief duration of this therapeutic intervention may not

provide a comprehensive understanding of the various ways DMT might be used to treat depressive symptoms in Asian American clients.

Perspectives for Future Research

The development of more effective and more culturally appropriate assessment and care should be pursued to improve treatment outcomes for Asian Americans. This would also prepare clinicians to be better suited to provide this population with better care (Koh, Chang, Fung, and Kee, 2007; Hyun, Nam, Kang, and Reynolds, 2009; Lam, Pepper, and Ryabchenko, 2004; Zane, Enomoto, and Chun, 1994). Since dance/movement therapy was described as helpful and culturally congruent on a small scale for the individual participant who was involved in this study, further research that evaluates the efficacy of dance/movement therapy in particular should be conducted. This research could take the direction of testing the efficacy of DMT for Asian Americans who descend from various nationalities, of various DMT structures and techniques, and of a longer course of treatment. Evaluating clients' willingness to seek and commit to DMT treatment may also be useful in better understanding and serving this population.

In addition to research on the efficacy of DMT, further studies that amplify the respective narratives of the participant and therapist may bring more light to the nature of the cross-cultural relationship, particularly in the context of DMT. Because the researcher did not attend to her thoughts about and responses to the therapeutic relationship in the researcher field notes, the data did not effectively capture the therapist's experience of the cross-cultural relationship. Researching similarities and differences in experiences of the

therapist and client in the therapeutic relationship over the course of DMT may provide further insight into best practices for cultural competency.

Researcher's Reflections

From a young age, I developed a curiosity about culture, likely as a result of seeing how my Italian American family did things differently than the families of my friends and others I knew. My interest in culture became codified when I chose to take an independent study in high school to do some research on the Italian American culture. This interest continued to amplify with my decision to study anthropology during my undergraduate career. I began studying the cultures of various ethnicities, but also the culture of the Western medical model as compared to complementary and alternative medicine. While studying dance/movement therapy, I often thought about the role of culture in mental health and how mental health manifests, is perceived, and is treated in various cultures. Considering the nature of stigma and the hesitancy to seek mental health treatment that I had read could be present in Asian American cultures, I wanted to investigate this topic in more depth, so I chose to study it for my thesis research.

The most ubiquitous consideration of mine was about balance. Balance was what I worried about and what I strove for. This theme dominated in my researcher reflexive process, and was also something I thought about frequently while conducting the DMT sessions with the participant. I wanted to be able to balance the role of researcher and therapist, knowing that these roles may align at times and may conflict at others.

Going into this process, I had several concerns. I was anxious about how I would be perceived by the participant. Because I place a lot of personal and professional value in

cultural competency, I was eager to be viewed as being sensitive to and respectful of the needs of the participant, both generally speaking as a therapist, but also within the cross-cultural relationship. I knew I should balance this desire with the truth that all I could be certain of being was openheartedly curious. I was cautious to temper my desire to prove my cultural competency and sensitivity and focus instead on the objective of the research and the needs and preferences of the participant in the moment.

My desire to be a culturally competent therapist, to attend to the needs of the client, and to be an objective researcher who tried not to influence the participant resulted in a diminished presence of myself in the sessions. By not fully acknowledging my own role in the therapy, some of the benefit of having a cross-cultural relationship may not have been fully realized. This also led to an absence of my own reactions to the relationship in my field notes, as I was instead focused on trying to represent the participant's perspectives. Through this process, I have come to realize that I have a tendency to step back and try to avoid influencing the participant, instead of realizing that I will inevitably have an influence and acknowledging and utilizing that role to positively affect the relationship.

As a student therapist, I was also nervous about my skills as a clinician. At times, I questioned my choices as both therapist and researcher. As I continued to work with the participant and our rapport increased, I became more comfortable and confident in my decisions and the shape that the process took. In the end, I found that working with the participant was an incredibly enriching process on many different levels. She presented with a complexity of demeanor, values, and beliefs that simultaneously affirmed what I had learned from the literature, while also frequently serving to remind me of the individuality of all people. I was grateful for her openness with me, willingness to try new things, and her

dedication to trying to help others through participating in this study. She taught me much about conducting research, being a clinician, and working towards becoming a culturally competent therapist.

CHAPTER 6: SUMMARY AND CONCLUSIONS

The objective of this study was to describe the dance/movement therapy (DMT) process as it developed with a Chinese American client with depressive symptoms. One participant was recruited to participate in this qualitative case study, which was comprised of an initial interview process, three DMT sessions with subsequent journaling and discussion time, and a final interview to obtain the participant's reflections on her experience with the DMT.

Five sources of data were collected, including the researcher's notes from the initial interview; researcher field notes, participant journal entries, and a transcription of the discussions between researcher and participant from each of the three DMT sessions; and then a transcription from the final interview.

Six themes emerged from the triangulation of these data sources: (a) the development of the therapeutic relationship, (b) the importance of dedicating time to understanding, (c) DMT as a support in expressing and accepting feelings, (d) valuing and experiencing relaxation and release, (e) the preference for a structured and solution-based therapeutic approach, and (f) the Chinese culture and views on mental health.

The findings suggest that dance/movement therapy may be a culturally congruent form of therapy for Chinese Americans with depressive symptoms and that it may provide an alternative method for expressing and releasing feelings that are discouraged from being verbalized.

The clinical implications include the therapist developing cultural awareness and focusing on therapeutic rapport, using the body to express feelings that are uncomfortable to verbalize, respecting privacy and confidentiality, being cautious in making clinical and

movement-based interpretations based on Western norms, and starting with a structured and solutions-based approach to the therapy.

Further research may investigate the efficacy of dance/movement therapy for Asian Americans of various nationalities and using various DMT techniques. More research to better understand how and when Asian Americans seek treatment and what the determining factors are in continuing their therapy would also be beneficial to determine the best way to reach this population.

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APPENDIX A: STUDY RECRUITMENT FLYER

VOLUNTEERS NEEDED TO PARTICIPATE IN A DANCE/MOVEMENT THERAPY RESEARCH STUDY

Research Title: An exploration of dance/movement therapy for Asian American clients with depressive symptoms.

Research Objectives:
This study is designed to understand how Asian Americans with depressive symptoms respond to a short course of dance/movement therapy. Culture plays an important role in therapy. The study will explore whether and how this therapy may be a match for people in this cultural group. There will be four participants in this study who will each participate in four dance/movement therapy sessions and an initial and final interview.

To Participate in this Study You Must:

- Currently have 3 or more of the following depressive symptoms:
  feelings of sadness or emptiness for most of the day; being tired or loss of energy; slowed responses or agitation; significant weight gain or loss or change in appetite; difficulty sleeping or sleeping too much; muscle tensions; bodily pain (including but not limited to stomach pain, headaches, and neck pain); loss of interest or pleasure in activities you used to enjoy; feelings of being worthless or guilt; difficulty in thinking, concentrating, making decisions, or remembering; feelings of hopelessness.
- Be of Asian background and live in the United States.
- Be a current client of [redacted] receiving services for at least six weeks.
- Be between 18 and 65 years of age.
- Have a basic understanding of English (reading, writing, and speaking).
- Not have psychotic symptoms, dementia, or mental retardation.
- Not have thoughts or plans to harm or kill yourself.
- Not have a physical disability or pain that makes you unable to do mild physical activity.

You do not need to have a diagnosis of depression to participate in this study.

Please Note: Participation in this study is entirely voluntary. Total time commitment is approximately 4 hours and 35 minutes.
Location: [redacted]

Contact: Contact **Julia Cuccaro** for more information if you are interested in participating in this study: **drexel.asia.dmt@gmail.com or [redacted].**

This research is being conducted by a member of Drexel University

APPENDIX B : EMAIL RESPONSE SCRIPT

Dear ,

Thank you for your interest in participating in the study, "An exploration of dance/movement therapy for Asian American clients with depressive symptoms." Please let me know when a good time for me to call you would be and list a phone number where I can reach you at that time. I am most available in the evenings and on weekends. I will confirm a time by return email.

During this phone call, I will provide you with more information about this study, as well as answer any questions you may have. We will also review eligibility criteria at this time. If you continue to be interested in participating in the study, we will arrange a time to meet at [redacted] to begin the study procedure.

Thank you again for your time. I look forward to hearing from you.

Julia Cuccaro
Co-investigator

APPENDIX C: PHONE RECRUITMENT SCRIPT

Hello, my name is Julia Cuccaro. Am I talking to ? I'm calling to return contact about your interest in participating in the research study "An exploration of dance/movement therapy for Asian American clients with depressive symptoms."

I would like to review study information with you. I am the co-investigator in this study and a candidate for my Master's degree in dance/movement therapy at Drexel University. I am conducting this study to fulfill degree requirements.

Are you interested in further considering participation in the study? I will review study information with you so that you know why it is being conducted and what participation involves.

The purpose of this study is to understand a short course of dance/movement therapy with Asian American clients with depressive symptoms. It will explore whether and how this therapy is a match for this cultural group by exploring your experiences of dance/movement therapy. It will develop beginning ideas for the treatment of depressive symptoms in Asian American clients using dance/movement therapy.

If you participate in this study I will ask you to participate in five separate meetings, a total of five hours and ten minutes, which includes two interviews and four dance/movement therapy sessions. The initial meeting will be 65 minutes in length. The next three sessions will each be 60 minutes, and the final interview will be 30 minutes long.

I will audio record the interviews for transcription purposes and delete the audio recordings once all data has been collected and they have been transcribed.

The audio recordings and written transcriptions will be stored without information that identifies you, in a secure file in the Department of Creative Arts Therapies at Drexel University.

Participation in this study is completely voluntary. You may decline to answer any questions or withdraw from participation at any time.

May I review participation criteria with you?

You are eligible to participate in the study if:

- You currently have 3 or more of the following depressive symptoms: feelings of sadness or emptiness for most of the day; being tired or loss of energy; slowed responses or agitation; significant weight gain or loss or change in appetite; difficulty sleeping or sleeping too much; muscle tensions; bodily pain

(including but not limited to stomach pain, headaches, and neck pain); loss of interest or pleasure in activities you used to enjoy; feelings of being worthless or guilt; difficulty in thinking, concentrating, making decisions, or remembering; feelings of hopelessness.

- You are of Asian background and live in the United States.
- You are currently a client at [redacted] and have been receiving services for at least six weeks.
- You are between 18 and 65 years of age.
- You have a basic understanding of English (reading, writing, and speaking) .

You are not eligible to participate in this study if:

1. You have psychotic symptoms, dementia, or mental retardation.
2. You have thoughts or plans to harm or kill yourself.
3. You have a physical disability or pain that makes you unable to do mild physical activity.

Do you meet the criteria to participate in this study?

Do you have any questions?

Are you a still interested in participating in this study?

I'd like to set a date and time that I can meet with you to review the study again, your rights as a participant, obtain your written consent, and conduct the initial interview and dance/movement therapy session.

All meetings will take at [redacted] and [redacted], the director, will be present should you need support. The address is [redacted].

The time will be set

May I send an email in the week prior to the interview to remind you of the interview time and place?

Thank you for your time and I look forward to meeting with you.

If the recruitment contact declines to take part in the research: Thank you for your interest and the time you took to discuss the research study with me.

APPENDIX D: CONSENT FORM

Drexel University
Consent to Take Part
In a Research Study

- **Subject Name:** _____

- **Title of Research:**
  An exploration of dance/movement therapy for Asian American clients with depressive symptoms

- **Investigator's Name: Ellen Schelly Hill, MMT, ADTR, LPC, Principal Investigator; Julia Cuccaro, Co-investigator**

- **Research Entity: Drexel University**

- **Consenting for the Research Study:**
  This is a long and an important document. If you sign it, you will be authorizing Drexel University, and its researchers to perform research studies on you. You should take your time and carefully read it. You can also take a copy of this consent form to discuss it with your family member, attorney or anyone else you would like before you sign it. Do not sign it unless you are comfortable in participating in this study.

6. **Purpose of Research:**
   You are being asked to participate in a research study. A person's cultural background, beliefs, and values play an important role in health and distress and what is helpful to them. The purpose of this study is to understand what dance/movement therapy is like for Asian American people with depressive symptoms and the form that dance/movement therapy takes with Asian American clients. The study will explore how dance/movement therapy may or may not be a match for the ways Asian American clients see themselves, use support, and get better when they are feeling distress. The study will develop beginning ideas about how to use dance/movement therapy to help Asian American clients who have symptoms of depression. This research is being done as part of master's degree requirements at Drexel University.

   You have been asked to take part in this study because the following statements are true for you:

   1. **You have 3 or more of the following depressive symptoms:**
      feelings of sadness or emptiness; tiredness or loss of energy; slowed responses or agitation; weight gain or loss or change in appetite; difficulty sleeping or sleeping too much; muscle tensions; bodily pain (including but not limited to stomach pain, headaches, and neck pain); loss of interest or pleasure in activities you used to enjoy; feelings of being worthless or feeling

guilty; difficulty in thinking, concentrating, making decisions, or remembering; feelings of hopelessness.
2. You are of Asian background and are living in the United States.
3. You a presently a client at [redacted] and have been receiving services for at least six weeks.
4. You are able to function in your usual school, work and/or family roles.
5. You are between the ages of 18 and 65.
6. You have basic English skills in speaking, reading, and writing.
7. You have not been diagnosed with psychosis, dementia, or mental retardation.
8. You do not have thoughts or plans to harm or kill yourself.
9. You do not have a physical disability or pain that makes you unable to do mild movement activity.

Four people will participate in this study. You are volunteering for this study and may choose to end your participation at any time without problem.

7. **PROCEDURES AND DURATION:**

You understand that your time in the study will be a total of three (3) hours and 35 minutes. The study will take place over four meetings. The meetings will involve dance/movement therapy sessions, writing about the sessions, discussion, and interviews. The co-investigator will be the therapist in the dance/movement therapy sessions. The activities in which you will participate in each meeting are described in the sections following. The study will take place at [redacted]. Your other therapies at [redacted] will continue during the study and will be in place for you following the study.

Meeting 1 (Total time 80 minutes)

1. Initial Interview (20 minutes)
   The co-investigator will ask you about your background, your symptoms, life stresses, strengths, what you find supportive, therapy experiences, and movement activities that have been part of your life. This information will help the therapist support you in the dance/movement therapy sessions.

2. Dance/Movement Therapy Session (30 minutes).
   The co-investigator will guide a 30 minute dance/movement therapy session to give you a beginning understanding of what a dance/movement therapy session is like and to get to know you a little in movement. In the dance/movement therapy sessions you will use movement to give attention to feelings, thoughts, and actions. Dance/movement therapy sessions include three parts.

   a. Movement Warm-up. Sessions begin with a body warm-up of gentle movement and stretching designed to give attention to yourself and get your body ready to move more actively.

   b. Theme Development. During the middle section of the session the co-investigator will guide movement activities to support your strengths and which may explore problems you are having. During this section you may move actively, the co-investigator may suggest movement, you may make up your own movements, or may express a thought or feeling using movement. What happens

during a session is not planned ahead but is decided during the session by the therapist depending on what is going on with you at the time and your interests. Often the movement activity will relate to your life. The co-investigator will be interacting with you during the session, sometimes guiding you, sometimes moving with you, sometimes talking with you.

c. Closure. At the end of each session there will be a closing activity in which the co-investigator will guide relaxed movements and support you in finding movements and words that look back at what happened in the session. This closing activity is meant to help you feel settled and ready to leave the session.

3. **Journaling and Discussion (15 minutes)**
   After the session you will be asked to think and write in a notebook about how you felt about the movement and in what ways you found the movement and the co-investigator helpful to you or not. You and the co-investigator will also talk about this afterward. The co-investigator is interested in what the sessions are like for you. The co-investigator will record this discussion on an audio recorder and collect what you have written. The recording is so that the co-investigator can recall what was said. The co-investigator will also write her own notes about the session.

Meetings 2 & 3 (Total time each meeting: 60 minutes)

1. **Dance/Movement Therapy Session (45 minutes)**

   During Meetings 2 & 3 you will participate in additional dance/movement therapy sessions. Each session will include a beginning body Warm-Up, a middle part of the session called Theme Development, and Closure activity as described for Meeting 1.
   In each of these meetings the therapist will provide guidance, move with you, and talk with you. The activity will be based on what is going on with you and your interests.

2. **Journaling and Discussion (15 minutes)**

   After each of the Dance/Movement Therapy sessions in Meeting 2 & 3, you will be asked to think and write in a notebook, as you did in the first meeting, about how you felt about the movement and in what ways you found the movement and co-investigator-therapist helpful to you or not. You and the co-investigator will again talk about this afterward, and the co-investigator will record this discussion on an audio recorder and collect what you have written.

Meeting 4 (Total time 30 minutes)

Final Interview.
After the three dance/movement therapy sessions the co-investigator will schedule a time for a final interview to learn more about what the dance/moment therapy sessions were like for you. This interview will take place in an in-person or phone meeting according to your preference.

8. RISKS AND DISCOMFORTS/CONSTRAINTS :

The overall possibility that you will experience harm from being in this study is very low. There is a small possibility of pain or stress from movement activity. The dance/movement therapy sessions will include a body warm-up to ready your body for movement. You can stop or change your movement if you have any stress. You may feel nervous or uncomfortable if you are not used to expressing yourself in movement. You may also feel some discomfort in noticing and expressing feelings or discussing your health and concerns in the interviews or dance/movement therapy sessions. It is your decision what you choose to share. The dance/movement therapy sessions will close with relaxed movement and discussion meant to support you in feeling settled at the end of the session. If you experience more than mild distress you are encouraged to speak with [redacted], the director of [redacted]. Persons who feel depressed sometimes have thoughts of hurting themselves, though this is not a risk of the study itself. The co-investigator will inform the director of the center if she has any concerns about your safety; the director will further assess, communicate with your primary therapist, and arrange additional support if needed. You will continue to be involved in your regular therapy at [redacted] during the study and may continue following the study as well. There are additional services for you if you need them. Because there are audio recordings and written notes involved in this study, there is a possibility that someone could learn about you and know who you are. However, the co-investigator has taken steps to lessen this possibility, by storing the records with a number instead of your name and keeping the records stored in a locked file cabinet in the Department of Creative Arts Therapies.

9. UNFORESEEN RISKS:

Participation in this study may involve unplanned risks. If unplanned risks are seen, they will be reported to the Office of Regulatory Research Compliance.

1. BENEFITS:

There may be no direct benefits from participating in this study. Participants may benefit from the therapy session provided in this study.

2. ALTERNATIVE PROCEDURES:

The alternative is <u>not</u> to participate in this study.

3. REASONS FOR REMOVAL FROM STUDY:

You may be required to stop the study before the end for any of the following reasons:

1. **If all or part of the study is ended for any reason by the investigator, or university authorities.**
2. **If you do not meet the requirements for participation established by the co-investigator.**

a) VOLUNTARY PARTICIPATION:

Participation in this study is voluntary, and you can refuse to be in the study or stop at any time. There will be no negative consequences if you decide not to participate or to stop. Your healthcare will not be affected should you decide to not participate or withdraw at any point.

1. **RESPONSIBILITY FOR COST**

You will not be responsible for any costs in this study. Any materials needed for the study will be provided by the co-investigator.

2. **IN CASE OF INJURY:**

If you have any questions or believe you have been injured in any way by being in this research study, you should contact Ellen Schelly Hill at telephone number [redacted]. However, neither the investigator nor Drexel University will make payment for injury, illness, or other loss resulting from your being in this research project. If you are injured by this research activity, medical care including hospitalization is available, but may result in costs to you or your insurance company because the University does not agree to pay for such costs. If you are injured or have an adverse reaction, you should also contact the Office of Regulatory Research Compliance at 215-255-7857.

3. **CONFIDENTIALITY:**

In any publication or presentation of research results, you will not be identified in any way, but there is a possibility that records that identify you may be inspected by authorized individuals such as the institutional review boards (IRBs), or employees conducting peer review activities. You consent to such inspections and to the copying of excerpts of your records, if required by any of these representatives.

Each participant will be assigned a number (PIN number). Written records and audio-recordings will be labeled with this PIN and will not be stored with any information that identifies you.

The paper on which your PIN number and contact information are written will be stored separately from study records and will be shredded at the end of the last interview. The audio-recordings of the final interview and end of session discussions will be securely stored without information that identifies you. The co-investigator will copy the audio-recordings in written form on a CD and delete the audio-recordings after copying them. The CD and paper records, including copies of what you have written in notebooks, co-investigator notes, and notes from the first interview will be stored without information that identifies you in a locked file cabinet in the Department of Creative Arts Therapies as a record of the research and destroyed three years following the end of the study.

4. **OTHER CONSIDERATIONS:**

If you wish further information regarding your rights as a research subject or if you have problems with a research-related injury, for medical problems, please contact the Institution's Office of Regulatory Research Compliance by telephoning 215-255-7857.

18. CONSENT:

- **I have been informed of the reasons for this study.**
- **I have had the study explained to me.**
- **I have had all of my questions answered.**
- **I have carefully read this consent* form, have initialed each page, and have received a signed copy.**
- **I give consent voluntarily.**

_____ _____

Subject or Legally Authorized Representative **Date**

_____ _____

Investigator or Individual Obtaining this Consent **Date**

List of Individuals Authorized to Obtain Consent

Name	Title	Day Phone #	24 Hr Phone #
Ellen Schelly Hill	Principal Investigator	[redacted]	[redacted]
Julia Cuccaro	Co-Investigator	[redacted]	[redacted]

APPENDIX E: PARTICIPANT CONTACT AND CODING FORM

Participant Name: _____

Participant Phone Number: _____

Participant Email Address: _____

Participant Identification Number (PIN): _____

Date and Time of Meetings:

Initial Meeting, Informed Consent, Initial Interview, DMT Session 1): _____

Second Meeting (DMT Session 2): _____

Third Meeting (DMT Session 3): _____

Final Interview: _____

APPENDIX F: INITIAL INTERVIEW GUIDE

This interview will be twenty minutes in length. The purpose of this interview is to gather information relevant to the study with regard to participants' history, cultural affiliation and practices, perspectives on mental health, history of symptoms, stresses and coping resources, and past therapy and movement experiences.

Demographic and Background Info

1. How old are you?

2. How long has your family been in the United States?

3. With what ethnicity and nationality do you identify? Do you consider yourself American?

4. How engaged are you in cultural activities from this nation? Those of your ethnic heritage? Are there any cultural practices or beliefs that are particularly important to you?

History of Depressive Symptoms

5. What are your symptoms and how long have you been experiencing them?

6. Do you have any current stressors in your life?

7. What do you think about depression and its causes?

8. What do you think would be most helpful to work on these?

9. What personal strengths or practices are helpful to you in coping with your stressors and depressive symptoms? What social or other supports are helpful to you?

10. Have you been involved in therapy? Please describe.
    a. What did you find helpful and what didn't you?
    b. What do you think could improve this and what things should be considered in your therapy?
    c. Have you ever been prescribed medication for your symptoms?
    d. What is your opinion of medication as a therapeutic support?

11. How does your culture view or react to depression (friends, family)?

12. What made you decide to seek professional therapy for your symptoms, and do you feel supported in this decision?

13. Do you have any previous experiences with dance or other movement disciplines? Please describe.

14. What practices do you do to promote health? Do you visit doctors regularly?

APPENDIX G: JOURNALING PROMPTS

The questions below may help you reflect on your experience of the session. You do not have to respond to all of these questions.

1. How did I feel before this session? During? After? Did this session affect how I feel?
2. What movement activity or experience did I find helpful? What was not helpful?
3. What was helpful about my relationship with the therapist? When did I feel understood or misunderstood?
4. Was this session respectful of my cultural values and beliefs about healthcare? In what way?
5. Other comments or questions I had…

APPENDIX H: RESEARCHER OBSERVATIONAL FIELD NOTES FORM

Structure of Session (including DMT methods used):

Emerging Themes:

Movement Qualities:

Meaningful Movement Phrases and Interactions:

The Therapy Relationship:

General Observations:

APPENDIX I: FINAL INTERVIEW GUIDE

As necessary, the co-investigator will refer to journal entries, discussion transcripts, and researcher observation notes for purposes of elaborating responses and reflecting on the experience.

Preface: Hello, _____. This is a final interview to check in with you to see if you have had any more thoughts about your experiences with the dance/movement therapy sessions since we last met.

1. What are your current depressive symptoms? Any changes in the intensity, frequency, or duration of these symptoms?

2. Was dance/movement therapy helpful for you in reference to your depressive symptoms? How?

3. Did you feel committed to this therapy during the sessions? Between sessions?

4. Would you recommend dance/movement therapy to a friend of Asian decent who has depressive symptoms?

5. What did you find meaningful or helpful about the dance/movement therapy sessions?

6. What did you find unhelpful about the dance/movement therapy sessions? Was anything objectionable or upsetting to you?

7. Looking back over the four sessions, how would you describe your overall response to dance/movement therapy?

8. Did you experience the dance/movement therapy sessions as supportive to you within your cultural beliefs and values about healthcare? How so or how not?

9. Would you like to add to any of the comments you made in your journal entries and our earlier discussions about the dance/movement therapy sessions and your involvement in them?